Young people’s experiences of attending solution focused brief therapy: an interpretative phenomenological analysis

by

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Volume 1: Academic and Research Dossiers, and Summary of Clinical Dossier

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INTRODUCTION TO THE PORTFOLIO

The portfolio is a compilation of the academic, clinical and research work completed for the degree of Doctor of Psychology (Clinical Psychology) for the University of Surrey.

The work presented in the academic dossier demonstrates an understanding of a wide range of different topics and issues within psychology. The clinical dossier presents work which reflects the range of different client groups and presenting problems covered during the course and the ability to formulate within a variety of models of psychological therapy. The research dossier demonstrates competence and understanding in the use of different research methodologies.

Volume 1
This volume contains the academic dossier, a summary of the clinical dossier and the research dossier. The academic dossier contains four essays completed over the first two years of training. The summary of the clinical dossier contains summaries of the five case reports and six clinical placements completed during the course. The research dossier contains the service-related research project completed during the first year, the major research project completed in the third year and a research checklist which details the research skills gained during the course.

Volume 2
This is the confidential clinical dossier which presents details of the clinical experience gained during the three years of training. This contains five detailed case reports of work conducted whilst on placement; contracts and evaluation forms for each placement; and summaries and logbooks of clinical experience for each placement.
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ACADEMIC DOSSIER

This section of the portfolio contains four essays completed over the first two years of the course, and demonstrates an understanding of a wide range of different topics and issues within psychology.
A case formulation within a cognitive behavioural model is a desirable, though not essential part of the therapeutic process and planning of the intervention. Critically discuss this statement.
INTRODUCTION

Over recent years formulation has held a place of importance within the profession of clinical psychology. Dave Harper (2003) highlights that the Division of Clinical Psychology’s (DCP) Core Purpose and Philosophy of the Profession, states that formulation is one of the core skills of a clinical psychologist. The DCP suggests that formulation ‘is the summation and integration of the knowledge that is acquired by this assessment process’ (DCP, 2001; pp. 3). Case formulation (CF) approaches have been developed within various theoretical orientations, including psychodynamic, cognitive, behavioural and biological. The nature of the formulation can vary depending upon the theories the clinician applies (Eells, 1997). Bieling and Kuyken (2003) suggest that for the cognitive therapist, as a scientist-practitioner, ‘case formulation is the heart of evidence-based practice’ (pp. 53).

This essay will critically discuss whether CF within a CB model is a desirable, though not essential part of the therapeutic process and planning of the intervention. The author describes the origin of CF in CB models, and provides a definition of CF. Person’s (1989) systematic CF approach will be described, followed by description of the role of CF and the proposed benefits of using this approach. The limited amount of research that has been conducted into CF will then be discussed in an attempt to establish whether the proposed benefits for the role of CF can be supported. Comparative research of manual based CB treatments with more individualised (formulation based) CB treatments will be discussed in relation to the claimed benefits of CF in guiding choice and timing of interventions, treating complex cases and for tailoring manual based treatments to the individual. A potential risk of CF approaches for intervention selection will also be discussed. Research into the reliability of CF will then be discussed, followed by exploration of the research into CF and the therapeutic process. This will focus on claimed benefits for managing the therapeutic relationship, the impact of CF on therapeutic alliance, and for managing non-compliance. Finally the author concludes that CF appears to be desirable from a theoretical basis, but speculates why CB CF has become accepted in the absence of the empirical research.
CASE FORMULATION IN COGNITIVE BEHAVIOURAL MODELS

CF within a CB model has developed out of a combination of cognitive theories and the behavioural practice of functional analysis, (Persons & Tompkins, 1997). The behavioural CF approach developed due to dissatisfaction with psychiatric diagnosis, and behaviour analysis was seen as an alternative (Kanfer & Saslow, 1965; cited in Tarrier & Calam, 2002). The influence of cognitive therapy turned attention away from external stimuli in the individual’s environment, and towards factors internal to the patient, such as thought processes (Tarrier & Calam, 2002). Eells (1997) highlights that general formulations for specific disorders was the focus of cognitive therapy in its early days. These general models emphasised cognitive patterns, beliefs and styles of processing that were common to specific disorders. Eells (1997) suggests that Persons' (1989) book on CF within a CB model has resulted in the increased focus on the importance of individualised CFs in CB models.

Definition of case formulation

Tracy Eells (1997) provides a working definition of psychotherapy CF which states that it is ‘essentially a hypothesis about the causes, precipitants, and maintaining influences of a person’s psychological, interpersonal, and behavioural problems’ (pp. 1). Tarrier and Calam (2002) provide a clear description of CB CF including the following elements:

1. CF involves obtaining relevant information which can then be integrated with theory in order to begin to understand the origins, development and maintenance of the individual’s problem.
2. This overview and explanation is then subject to verification through hypothesis testing.
3. The therapist and client can then reach a collaboratively agreed understanding of the individual’s problems.
4. This is then used to identify targets for change and inform and plan the intervention.
Persons' (1989) Case Formulation Approach

A number of CF approaches in CB models have been developed to provide clinicians with a systematic method for developing CFs (e.g. Persons 1989, 1993; J. Beck, 1995; Needleman, 1999 cited in Bieling and Kuyken 2003). The author has chosen to describe Persons’ approach to CF as this has received the most attention in the literature at present.

Persons (1989; 1993) CF model is based on Beck’s cognitive theories of psychopathology and behavioural CF approaches, developed by Turkat and colleagues (e.g. Turkat & Maisto, 1985; cited in Persons 1993). Persons highlights that this approach is influenced by the practice of behavioural analysis, but places a larger emphasis on the role of cognitions. This model views individual’s problems as existing at two levels: overt difficulties and underlying mechanisms. She describes overt difficulties as “real life” problems. Underlying mechanisms are psychological processes that cause and maintain the overt difficulties the individual describes, such as dysfunctional attitudes or beliefs about the self, others and the world. This includes conditional beliefs and absolute beliefs.

Persons states that underlying mechanisms, in interaction with life events, can be seen as the cause of the overt difficulties, and the overt difficulties maintain the underlying mechanisms. Persons concludes that change at one level should produce change at the other level. Environmental factors are also considered to play a powerful role in triggering and eliciting underlying beliefs and overt difficulties.

There are seven components of the CB CF. The Working Hypothesis is considered to be the ‘heart of the formulation’ (Persons & Tompkins, 1997: pp. 319) and aims to tie together the information in the Core Beliefs section, Precipitants and Activating Situations section, and Origins section to tell a story that accounts for the exhaustive Problem List. This results in a detailed Treatment Plan and consideration of Predicted Obstacles to Treatment sections.
ROLE OF CASE FORMULATION IN CB MODELS

A number of authors have written about the desirability of CF within a CB model. Clark, (1999) suggests that 'the importance of CF and conceptualization is clearly evident in the writings of cognitive therapists' (pp. 331). Words such as crucial (Beck, 1995), advantageous (Williams, Williams & Appleton, 1997), essential (Mumma, 1998), and important (Clark, 1999) are commonly found in the literature on CF in CB models. Case studies or examples are often presented as providing support for CF in CB models. The argument seems to focus on the assumption that the CF provides the therapist and client with information to aid the therapeutic process and plan interventions, which would not be available if a CF approach had not been adopted. Furthermore, the systematic process of gathering this information and testing hypotheses throughout enables the clinician to continually reformulate if appropriate. The author's review of the literature highlights that the 'role' of CF in CB models is often discussed as support for the desirability of CF.

Persons' (1989) proposes some important roles of the CF approach in cognitive behaviour therapy (CBT). She highlights that although the cognitive model of understanding psychopathology explains the relationship between cognitions, emotions and behaviour, this model does not guide the therapist in selection or timing of interventions. She suggests that the CF approach is desirable for the planning of the intervention as it assists the therapist in understanding the relationship among the individual's problems, choosing an intervention strategy, and choosing an intervention point. Persons and Tompkins (1997) suggest that CF may be beneficial for treatment of individuals with multiple problems (co-morbidities). In relation to the therapeutic process Persons suggests that the CF approach helps the therapist to: manage the therapeutic relationship by predicting the client's behaviour and guiding therapist style; understand and manage non-compliance; and redirect unsuccessful treatment. Persons (1989) provides case examples as support for the approach, yet it is unclear whether these are 'real' cases or cases created from clinical experience for demonstration purposes.
RESEARCH INTO CASE FORMULATION APPROACHES

There has been relatively little direct research into CF approaches in CB models. Research has been conducted that compares manual based treatments and individualised treatments. This focuses mainly on the planning of interventions and treatment outcome. Research has also looked at the reliability of CF approaches and the impact of CF on the therapeutic process.

Manual based versus individualised case formulation treatment

In order to claim that individualised CF is desirable in CBT there needs to be evidence of the benefits of using a CF approach. One of the ways this has been debated indirectly is by comparing manual based treatments and individualised CF treatments, as an important focus of the CF approach in CB models is that treatment is based on an understanding of the individual client. Manual based treatments are general treatments that have been empirically validated for specific disorders or presenting symptoms. Wilson (1996) debates the desirability of CF and suggests that manual based treatments should be considered as an alternative. He states that treatment manuals in CBT are structured, time limited and highly focused which can facilitate engagement in the therapeutic process, combining core elements of CBT in a systematic structure. This research will be discussed in relation to potential benefits and risks of CF approaches for intervention planning.

The use of case formulation in guiding intervention choice and timing

Persons (1989) proposed that CF is desirable as it can help guide the therapist in choice and timing of interventions. Jacobson, Schmaling, Holtzworth-Munroe, Katt, Wood and Follette (1989) compared treatment where therapists administered the prescribed modules in a set order, to more individualised treatment where the manual was tailored to the individual. In the latter the therapist was given flexibility in which modules to implement, and the order, timing and duration of each. The clinicians only used the modules that were identified as appropriate according to the CF. The results indicated that at post treatment both the individualised and standardised treatment
groups’ demonstrated significant improvements. In support for individualised treatment, in the 6-month follow up the client’s who had received the individualised treatment were more likely to have maintained their improvements (Jacobson et al 1989). Bieling and Kuyken, (2003) highlight that this study provides some support that CF is desirable for selecting appropriate interventions and for guiding the timing of these interventions.

In comparison, Schulte, Kunzel, Pepping and Schulte-Bahrenberg (1992) found no evidence that using a CF to plan interventions improved treatment outcome. They compared effectiveness of three treatment groups of phobic patients (N = 120). They found that standardised treatment was more effective then individualised treatment. In one group the therapists treated the clients using a standardised treatment of *in vivo* exposure and self-statement training. In the individualised group the therapists were able to choose which cognitive or behavioural approaches to implement, therefore using the CF to plan the interventions. They also included a control group where individuals received the same treatment as one individual from the individualised treatment group. They compared treatment effectiveness at the end of treatment and at a 2 year follow up and found that the standardised group demonstrated the most improvement on both occasions. In fact, the control group showed equal improvements to the individualised group. This study does not therefore suggest that a CF approach is more desirable than a manual based approach in CB model.

*Tailoring treatment manuals using case formulation approaches*

Persons and Tompkins (1997) suggest that one explanation for results found in the Schulte et al (1992) study arose from the reported observation that therapists in the manual based group did not adhere completely to the manual, thus there was less difference between the two groups than was intended. This raises questions about whether manual based treatment precludes CF. Persons and Tompkins suggest that standardised treatment protocols used in outcome studies may not produce detailed formal formulations, but the therapists still tailor the treatments to the individual. They do this by focusing on an individual’s dysfunctional beliefs/attitudes rather than
attempting to focus on typical dysfunctional beliefs or attitudes held by individuals with particular diagnoses or symptoms.

Mumma (1998) questioned the assumption that manual based treatments preclude CF, suggesting that some manual based treatments ‘require a formulation of the patient as part of the treatment program’ (pp. 251). He suggests that manual based treatments could benefit from using CF approaches to tailor the order, length or timing of different treatment components to the individual. This is supported by Jacobson’s et al (1989) finding that the flexibility of choice and timing of interventions in the individualised group resulted in lower relapse rates. Bond (1998) suggests that treatment manuals could be tailored to individuals through the implementation of a CF approach. He claims that even interventions that are considered to be “straightforward” (e.g. exposure and response prevention) need to be tailored to the individual. Bond suggests that a CF approach may provide the clinician with a guide to obtaining the relevant information necessary for this tailoring process.

The research reported above appears to support the use of CF to tailor manual based treatments for improved outcomes in the long term. This conclusion can only be made tentatively, and this is an area that would benefit from further research.

*Case formulation beneficial in cases of co-morbidity*

Emmelkamp, Bouman and Blaaw (1994; cited in Wilson, 1996) compared CB standardised treatment and CB individualised treatment of individuals with obsessive-compulsive disorder (OCD). The standardised group involved self-directed exposure and response prevention only. The individualised group had scope to address additional issues to OCD such as coping strategies, social anxiety, and were able to use a variety of treatment techniques such as cognitive therapy, marital therapy and assertion training. The results found that the two treatment groups were equally effective in reducing the symptoms of OCD. Persons and Tompkins (1997) highlight that most clients in this study and the Schulte et al (1992) study presented with one distinct disorder. They suggest that CF approaches may be shown to be beneficial to individuals with co-morbidity. Mumma (1998) also suggests that when manual based
treatment is not available, (e.g. in complex cases of multiple problems) it may be appropriate to use a CF approach. In support of this, Persons and Tompkins, describe a naturalistic study in which 45 clients with depression were treated by Persons using an individualised CBT approach guided by a CF. These individuals showed similar treatment outcomes to individuals who had been treated using standardised CBT in the NIMH Treatment of Depression Collaborative Research Program (Elkin et al 1989; cited in Persons and Tompkins 1997). Importantly they suggest that most of the individuals that Persons treated had co-morbidities that would have excluded them from the standardised CBT Research program. This may provide support for the use of CF in CBT when co-morbidities exist, however much further research is needed into the effectiveness of CF approaches in CBT before such conclusions can be made.

Wilson (1997) suggests that a CF approach may not be necessary. A logical strategy for managing individuals presenting with co-morbidity would be to treat their problems sequentially using manuals if they exist. Persons and Tompkins (1997) highlight that treating problems sequentially with manual based treatments is problematic because there is often overlap in the interventions suggested for different disorders. Furthermore, they highlight that this method does not provide the clinician with any guidance on the order and timing of interventions. Persons and Tompkins also suggest that CF might be beneficial in multiple problem cases by providing the inexperienced therapist with a framework for understanding how problems relate both to each other and to the individual’s core beliefs. It is important for further research to be conducted into the efficacy of using CF and other approaches in treating clients with multiple problems.

The importance of using empirically-validated interventions

Wilson, (1996) highlights that one explanation for the superiority of standardised treatments found in the Schulte et al (1992) study is that a number of therapists in the individualised group failed to use in vivo exposure. When they reanalysed the data separating out those individuals who used in vivo exposure from those who did not, they found that the individualised and standardised groups performed equally. Wilson highlights that an underlying problem with CF in CB models is that therapists reject
the empirically-validated method and instead chose methods based on their own clinical judgement. Therefore, it appears that individualised treatments may increase the likelihood of clinicians rejecting empirically validated interventions. Wilson, (1996) suggests that the constrained flexibility in the Jacobson et al (1989) study ensured that the therapists used empirically validated methods. Thus CF may be a desirable part of the planning of interventions, on the condition that clinicians still implement empirically-validated interventions.

**Summary of manual based versus individualised based research**

The research on the effectiveness of manual based treatments and individualised based treatments provides mixed support for the benefits of CF. There is some suggestion that CF may be desirable as a means of tailoring manual based treatments to the individual, when treating complex cases of co-morbidity, and in the selection and timing of interventions. However, a potential disadvantage of CF is that it may lead to clinicians rejecting empirically-validated treatments and choosing interventions based on clinical judgement. Bieling and Kuyken, (2003) suggest that future research should focus less on whether CF directly affects treatment outcome, and more on whether CF affects treatment outcome indirectly through the selection of appropriate interventions. Wilson, (1997) concludes from his review of manual based and individualised based treatments, that CF approaches may be necessary when manual based approaches have been tried and the individual is treatment resistant, or when there are no empirically-validated approaches available.

Tarrier and Calam (2002) comment that comparison studies of standardised and individualised treatments are underpowered and would require extremely large numbers of participants to detect the differences in effect sizes. This would be extremely time consuming and expensive.

Wilson (1996) comments that most clinicians have uncritically accepted the argument that individualised CF should be the focus of clinical practice. He claims that the success of treatment manuals threatens this, and calls for a re-examination of the importance of CF. In criticism of CF approaches Wilson likens this approach to ‘a
particular instance of clinical judgment’ (pp. 299) and therefore suggests that CF is subject to the cognitive biases and errors known to act on clinical judgement and reduce the validity. Manual based treatments, on the other hand, involve implementing the most effective treatment available for specific disorders. It is therefore interesting to briefly look at some studies that have measured the reliability of CF approaches through measuring inter-rater reliability of clinicians CFs.

**Reliability of case formulation approaches**

Persons, Mooney and Padesky (1995) investigated the inter-rater reliability of CFs obtained by therapists using Persons (1989) systematic CB CF approach. They focused on therapist agreement in identification the problem list, and identification of underlying mechanisms. Overall, 65% or more of the clinicians identified each of the client’s overt problems. In relation to identifying underlying mechanisms, the authors reported that individual clinician’s reliability coefficients averaged at 0.46, a poor finding. The authors selected a random group of five clinicians and found improved reliability coefficients which averaged at 0.76. The findings from this study may not be representative of ‘real life’ formulations as clinicians only had audiotape footage of the interviews, conducted by another therapist. This will have limited the information available to them and prevented clinicians from asking questions of the client that would have allowed testing and development of their own hypotheses (Persons & Bertagnolli, 1999).

Persons and Bertagnolli, (1999) replicated the above study and tried to improve clinicians’ identification ratings of overt difficulties and underlying mechanisms. The results were similar to the above study, with clinicians identifying 67% of problems; single judge agreement in identification of schemas remained low, and was similarly higher when averaged across five judges. This finding, as above, suggests that clinicians may benefit from consulting with each other when identifying underlying mechanisms and that collaboration with the client may also increase reliability, (Persons & Bertagnolli, 1999).
Bieling and Kuyken, (2003) suggest that the research to date seems to indicate that clinicians are better at reliably identifying descriptive aspects of the CF (i.e. problem lists) than identifying inferential aspects of CF (i.e. identification of underlying mechanisms). Kanfer (1985; cited in Persons and Tompkins, 1997) suggests that inter-rater reliability of clinicians’ CFs is not a good indicator of the importance of CF. He argues that the process of information gathering through continual hypothesis testing is of more importance than initial agreement on a formulation. He further highlights that clinicians may follow different paths, starting from different initial formulations, but the need to follow an iterative process of hypothesis generation, testing, and amending as appropriate should be the focus (cited in Persons and Tompkins, 1997).

**CB case formulation approaches and the therapeutic process**

*Managing the therapeutic relationship through case formulation*

AuBuchon and Malatesta (1998) describe CF as a methodology for managing the therapeutic relationship. They suggest that a CF approach provides the therapist with a framework for understanding the client’s behaviour towards the therapist, as it gathers developmental data that can both predict and explain why individual clients may react to behaviour and characteristics of the therapist. Furthermore, they suggest that the CF can guide the therapist’s interaction with the client by indicating the best style to adopt. They present two case studies of complex individuals who had received treatment in the past that had been unsuccessful. They describe how information gathered through hypothesis generation, behavioural assessment, gathering of developmental history, and testing of the formulation, resulted in the unique planning of the interventions which focused on establishing a working relationship with the client. The therapist’s style was determined by the CF. The CF was shared with the client, and this guided the implementation of interventions. AuBuchon and Malatesta describe a specific relationship based intervention which they termed ‘therapist style’. This involved systematically varying certain therapist behaviours in accordance with the CF and experimentation in sessions.
AuBuchon and Malatesta, (1998) conclude that the two case studies presented provide initial empirical support for the use of CF approaches in managing the therapeutic relationship. Furthermore, this attention to the therapeutic relationship meant that the clients were able to benefit from empirically-validated treatments that may have been unsuccessful otherwise. There needs to be further research into therapist style as guided by the CF approach. There also needs to be research on a larger scale into whether the CF is the best and only way to manage therapeutic relationships, or whether CB therapists employing less systematic approaches are still achieving the same results.

The impact of case formulation on the therapeutic alliance

Persons and Tompkins (1997) suggest that sharing a CF with the client can strengthen the therapist-client collaboration. Chadwick, Williams and Mackenzie, (2003) conducted two experiments to investigate the impact of the CF approach in CBT for psychosis. Thirteen clients who had been referred for CBT with psychosis participated in the first study which aimed to assess client and therapists perception of the therapeutic relationship. The CF approach utilised in this experiment involved production of a diagram to analyse the current problem and maintaining factors, and provide details about onset of the problem, possible triggers, dysfunctional assumptions and core beliefs, and key experiences that contributed to these beliefs, (Chadwick et al, 2003). A letter accompanied this, which described the CF, isolated targets for treatment, and detailed potential obstacles for the therapeutic relationship. This formulation was shared with the client at the end of the first of two CF sessions. Participants completed self-report measures of anxiety and depression and a questionnaire of their perceptions of the therapeutic relationship on four occasions; two sessions before the formulation occurred, and two session when the CF was being developed and shared. The therapists also completed a self-report questionnaire of perceptions of the therapeutic relationship on the same occasions. Comments about the experience of formulation were gathered via semi-structured interviews. The study found that CF did not have an impact on client’s perception of the therapeutic alliance, but did have an impact on therapists’ perception of the therapeutic alliance. The interviews with the clients revealed that emotional responses to formulation varied,
some individuals reported only positive responses \( (n = 2) \), only negative responses \( (n = 2) \), both positive and negative responses \( (n = 4) \), and some reported no emotional responses \( (n = 3) \).

The second experiment completed by Chadwick et al (2003) found that strengths of delusions and negative self-evaluations decreased when direct challenging occurred in subsequent sessions. They suggest that any change that occurs after the sharing of the CF may in part be due to this process. However, it is clear that research into the impact of CF is very complex and vulnerable to many difficulties. For example, Chadwick et al (2003) acknowledge that the impact of CF in the long term was not assessed. Furthermore, CF may have impacted other aspects of the therapeutic process indirectly, such as preventing non-compliance. Chadwick et al (2003) conclude that the present experiments are ‘an initial step towards assessing empirically the importance of CF within CBT’ (pp. 679). Further research into CF in a variety of disorders is needed.

**Case formulation in managing non-compliance**

Greenberg (1983) highlights that positive outcome in therapy is associated with active participation in therapy by the client, (cited in Tompkins, 1999). Tompkins (1999) further states that clients can fail to attend, collaborate or comply, during therapy and that CF can ‘assist the therapist to manage such failures by providing a systematic way of thinking about the case’ (pp. 322). He describes a case example of a client with multiple problems and highlights how, in his opinion, the CF enabled him to (1) overcome difficulties in the client-therapist relationship and collaboratively agree on goals, (2) improve compliance with homework assignments and other tasks of therapy such as measures of treatment progress. He concludes that this therefore increased the likelihood of a successful treatment outcome. However without a comparison of how treatment would have progressed without CF it is difficult to conclude that the positive outcomes were a direct result of CF.
FURTHER CONSIDERATIONS

In the author’s experience and from the literature available, CF appears to be generally accepted as important in CB models, and other psychological orientations. In the author’s opinion, the CF appears to have potential benefits for both the therapist and the client, however at present there does not appear to be the research to support this. This raises the question as to why CF has been so readily accepted in the profession, at a time when evidence-based practice is emphasised. The author suggests that CF approaches may provide more opportunity for considering issues of diversity within the therapeutic relationship which may be overlooked when implementing more general formulations or manual based treatments. A formulation allows space for the therapist to reflect upon social, cultural and historical factors, and how these may influence both the therapist and the client’s views and assumptions. For example, therapist and client may not share cultural assumptions, and making a case formulation may allow the therapist to identify these factors and consider the potential influences they may have. The author agrees that CF provides a framework for understanding the client’s problems and difficulties in the context of their own lives. In the author’s experience, developing a CF is a way of organising the large amount of information gathered during assessment. The author has also felt encouraged to begin to develop hypotheses from the initial contact and test these hypotheses as the therapeutic process continues. This process has guided how the author interacts with the client.

It is currently unclear whether the claimed benefits of CF are achieved via other methods or processes. McWilliams (1994; cited in Eells, 1996) describes “fringe” benefits of CF in increasing clinicians’ confidence and sharpening the consistency and focus of interventions. The Chadwick et al (2003) study may support this as clinicians’ ratings of the therapeutic alliance increased after CF. It may therefore be fruitful to further explore how CF affects treatment outcome indirectly.

It is interesting to consider why there has been a lack of research into CF approaches, and why this approach has been accepted in this absence. Crellin, (1998) investigated the origins and social contexts of CF and concludes that the emphasis on this skill is
because it is seen as distinctive to clinical psychology and has been crucial in defining the profession. The author therefore speculates whether this has been influential in CF approaches becoming accepted, and whether this could explain the lack of research into the effectiveness of this "core" skill of clinical psychologists. The author suggests that it could potentially be detrimental to the profession if CF was found to be ineffective, and this may produce reluctance in researching the effects of this approach.

Bieling and Kuyken, (2003) identify a number of potential areas for further research into case formulation, starting with establishing how clinicians formulate in practice. Other areas include the reliability and validity of CFs, and importantly the link between CF and treatment outcome.

CONCLUSIONS

The author initially describes one of the early CF approaches Persons, (1989). Discussion initially focuses on research derived from comparison studies in relation to treatment outcome, followed by research into the reliability of CF in CB models, and the impact of CF on the therapeutic process. There appears to be theoretical support that CF within a CB model is desirable. However, there is little empirical research that has been conducted into CF within a CB model, and the research that has been conducted provides inconsistent results. The author speculates as to why CB therapists have accepted the CF without the empirical research to support it. There is a clear need for clinicians and researchers to attempt to conduct this research and consider why to date this has rarely occurred. In theory the CF approach in CB models seems to be desirable, but at present the research is inconclusive, therefore it would be difficult to claim that it is an essential part of the therapeutic process and planning of interventions.
REFERENCES


PEOPLE WITH LEARNING DISABILITIES

What role do clinical psychologists have in the assessment and treatment of people with learning disabilities who have been sexually abused? How can they assist with the prevention of such abuse?

Year 1: August 2004
INTRODUCTION

The reality that people with learning disabilities experience sexual abuse has been slow to emerge. Moss (1998) suggested that this was partly due to historical attitudes and beliefs about the sexuality of people with learning disabilities. Corbett, Cottis and Morris (1996) suggested that as people with learning disabilities were given more sexual rights and recognition of a right to a sexual life and identity, this has given them permission to speak about the inappropriate sexual activities that have happened to them. Over the past three decades considerable research has been conducted into sexual abuse of people with learning disabilities. Prevalence and incidence studies have raised concern as to the increased vulnerability of these individuals. Recent research has suggested that sexual abuse in people with learning disabilities is associated with a higher incidence of psychiatric and behavioural disorders (Sequeira, Howlin & Hollins, 2003). The increased risk of people with learning disabilities to experience sexual abuse is of great concern to all professionals working with this population.

This essay will look at the different roles a clinical psychologist may have in the assessment and treatment of people with learning disabilities who have been sexually abused and then consider how they can assist with the prevention of sexual abuse. A definition of sexual abuse will be provided followed by information relating to the prevalence and incidence of sexual abuse in people with learning disabilities. The role of a clinical psychologist in assessment, treatment and prevention will then be discussed in turn. Throughout the essay the author hopes to highlight that a clinical psychologist's role will involve work with the individual and the wider system. The author intends to focus on roles that are specific to clinical psychologists, although at times the role may be applicable to other professionals. This essay will highlight the potentially wide and varied role of a clinical psychologist which is dependent upon the individual's needs and current situation.
Definition of sexual abuse

Fenwick (1994) highlighted that for professionals to provide a logical and reasonable response to the sexual abuse of people with learning disabilities, an adequate definition is vital. Brown, Turk and Stein (1994) have provided a useful definition after considerable research in the area:

"**Sexual abuse consists of one-off assaults or of sexual acts within an on-going relationship in which the power differences are so great that they preclude the possibility of the person with learning difficulties freely giving their consent.**" (pp. 2)

They further state that these abusive acts can be non-contact (e.g. involvement in pornography; voyeurism) or contact (e.g. vaginal or anal intercourse; masturbation of either or both persons) and whilst usually involving acts performed by the abuser on the person who is abused, it might also involve situations where the abused person is forced/persuaded to perform acts on the abuser, (Brown et al. 1994). They also specify that it is important to establish whether the individual gave consent, could understand enough to give consent, or was under any undue pressure to give consent.

Prevalence and incidence of sexual abuse

A great deal of research has been conducted to determine the prevalence and incidence of sexual abuse amongst people with learning disabilities. The figures gathered in the research vary considerably, partly due to the definition of sexual abuse used, how data was collected and differences in the participants, (Beail & Warden, 1995). Prevalence studies have focused on identifying the number of individuals who have been sexually abused at some point during their lives and rates vary from 8% (Buchanan and Wilkins, 1991; cited in Hames, 1996) to 58% (Hard & Plumb, 1987; cited in Hames, 1996). The largest UK incidence study, conducted by Turk and Brown (1993) and the replication conducted by Brown, Stein and Tur (1995) predicted that 1250 cases would be recorded annually in England and Wales. The authors found that the perpetrator was predominantly male (96%), victims were both male and female,
the perpetrator was generally known to the individual, and the largest group of perpetrators were other service users, (Brown et al. 1995).

ASSESSMENT

In addition to being aware of the non-verbal signs and symptoms of sexual abuse, a clinical psychologist’s role may specifically involve assessment when allegations of abuse have been made, focusing on an individual’s capacity to consent and their credibility as a witness. Clinical psychologists may also assess the psychological impact of the abuse for the individual.

Assessment when allegations of sexual abuse have been made

Clinical psychologists may conduct assessments with individuals when an allegation of sexual abuse has been made. This may involve assessment of the individuals’ capacity to consent to sexual acts or their ability to be a credible witness in court (Joyce, 2003). Brown et al. (1995) found that the majority of cases of sexual abuse did not result in prosecution of the perpetrator. However, Green (2001) highlighted that in cases where prosecution occurs, assessment of the individual’s decision making skills are often requested. Clinical psychologists may assess the degree of the individual’s learning disability, as people with a severe learning disability are deemed unable to consent under the Sexual Offences Acts 1956 and 1967 (cited in Murphy 2003). Therefore, a clinical psychologist’s role may involve psychological assessment of intelligence using psychometric measures such as the Wechsler Adult Intelligence Scale and assessment of social functioning via the Vineland Adaptive Behaviour Scales (Sparrow et al. 1984; cited in Green 2001).

Capacity to Consent

Brown (1997) highlighted that clinical psychologists are often asked to provide assessments of capacity and decision-making skills for the investigation. The definition of sexual abuse by Brown et al (1994) stated that it is important to establish whether the individual gave consent, could understand enough to give consent, or was
under any undue pressure to give consent. According to the British Medical Association and Law Society Guide (1995), consent is dependent upon the individual’s capacity to understand what is proposed and the implications, and the individual’s ability to exercise choice, bearing in mind whether this was compromised by issues of power (as cited in Murphy 2003). Clinical psychologists will need to gather information about the individual’s sexual knowledge and understanding. Measures such as the Socio-Sexual Knowledge and Attitudes Test (Wish et al, 1979; cited in Green, 2001) could be used to determine the individual’s knowledge of the act and the implications. In assessing an individual’s sexual knowledge, Joyce (2003) found that cultural and ethnic issues need to be considered in these situations, for example in the words that are used to describe parts of the body and individual’s beliefs about talking about sexual activity. Discussion around choice and consent could be facilitated through the use of sex-education training packages which use pictures or videos to demonstrate individuals in situations that are abusive, (Green, 2001). In addition to this the clinical psychologist may assess whether the individual was under any undue pressure and therefore whether they willingly consented. This might be assessed by considering the relationship of the individual to the abuser and consideration of issues around power and acquiescence.

Assessing capacity to consent to sexual relationships is a difficult and problematic task, and to some extent relies on the assessor’s judgement as to whether the individual fulfils the criteria outlined above (Joyce, 2003). Further to assessing the individual’s capacity to consent, clinical psychologists may be called to be expert witnesses and assessment may involve consideration of whether the individual would benefit from someone acting on their behalf (Green, 2001).

Witness credibility

A clinical psychologist’s role may also involve assessment of the individual’s competency to give evidence in court and the reliability of this evidence (Joyce, 2003; Green, 2001). When determining whether an individual is competent as a witness, Green (2001) described the importance of assessing whether the individual could understand the oath. Green described assessing the individual’s understanding of the
difference between truth and falsehood through asking a number of simple questions relating to fact. Short stories could also be used to illustrate what is meant by the ‘whole truth’ (Green, 2001). Therefore, a clinical psychologist’s role may include an element of education and then assessment of individual’s ability to differentiate ‘truth’ and ‘untruths’ and understand the implications of not telling the truth in court.

If the individual is considered to be a credible witness, a clinical psychologist may also be asked to assess their ability to give a reliable account of the abuse. This may involve considering the individual’s ability to cope with cross-examination and their susceptibility to suggestion and acquiescence, (Green, 2001; Joyce, 2003). The Gudjonsson Suggestibility Scale (Gudjonsson, 1997; as cited in Green, 2001) can be used to assess the individual’s response to leading questions and tendency to give negative feedback. This information could also be used to provide the court with information about how the individual should be questioned to ensure that the testimony is not compromised (Green, 2001). Clinical psychologists may have a role in communicating the message that people with learning disabilities can be credible witnesses and draw attention to the importance of providing appropriate support to facilitate this.

**Assessment of the psychological impact of sexual abuse**

A clinical psychologist’s role when assessing survivors of sexual abuse may involve assessment of the psychological impact of the abuse. Although research into the impact of sexual abuse on children and adults in the general population has been vast, there has been less research specifically with people with learning disabilities (Sequeira & Hollins, 2003). Sequeira and Hollins (2003) reviewed a number of studies looking at the clinical effects of abuse. They suggested that whilst a number of problems exist in the research, people with learning disabilities appear to experience a range of psychopathology similar to the general population (e.g. withdrawal, self-injury, behavioural difficulties, low self-esteem). Sequeira et al. (2003) found that people with learning disabilities who had been sexually abused experienced a higher incidence of psychiatric and behavioural disorder.
O’Callaghan, Murphy and Clare (2003) found that a framework for assessing post-traumatic stress disorder which utilised carers’ accounts of the individual’s symptoms was a useful and meaningful way to examine the impact of abuse on both men and women. They found that it was potentially beneficial when assessing individuals with more severe learning disabilities or more limited communication. Clinical psychologists may use such measures when assessing for the psychological impact of sexual abuse on people with learning disabilities.

Assessment of the psychological impact may help staff and carers understand the individual’s behaviour or distress. Assessment of the impact of abuse would be important for understanding the origins of present difficulties, highlighting areas that are most problematic for the individual and guiding any future interventions or treatment. Furthermore, O’Callaghan et al. (2003) highlighted that psychological distress as a result of abuse must be demonstrated if an individual is to receive compensation in a civil court. Therefore, clinical psychologists may be asked to assess the impact of abuse on the individual’s psychological health before they go to trial.

**TREATMENT**

The role of a clinical psychologist in the treatment of people who have been sexually abused is likely to be varied and could involve direct interventions with the individual or indirect interventions through carers, family or staff.

**Direct work with client**

Clinical psychologists may work individually with people with learning disabilities who have been sexually abused. This may involve working therapeutically with individuals where sexual abuse is suspected and facilitating disclosure. Corbett et al. (1996) suggested that it is important to provide the individual with ‘a space’ where their voice can be heard, and that disclosure is the beginning stage of the healing process. The role of a clinical psychologist may be to witness this disclosure and respond in a way that provides the survivor with the message that they are believed and that they will be supported (Corbett et al. 1996). Once disclosure has occurred,
clinical psychologists may have a role in supporting individuals through criminal proceedings or providing psychotherapy.

**Supporting individual through criminal proceedings**

Green (2001) highlighted that clinical psychologists may have a role in preparing people with learning disabilities who have been sexually abused to go to trial. This may involve working in conjunction with other professionals to help prepare the individual to give evidence or go to trial. Green (2001) highlighted that this could involve individual or group work in relation to developing coping strategies for dealing with stress and panic when giving evidence. In these situations it may be important to consider who undertakes this role to avoid any conflict of interest, (Green, 2001). Willott, Rabone, Offen and Pratap (2004) suggested that clinical psychologists may have a special role in supporting individuals during the criminal justice procedure to ensure that they feel empowered by the process. They commented that many of the cases of alleged abuse do not proceed to a court hearing and highlight that individuals may feel disempowered as they do not have the opportunity for their version of the event to be heard. On the other hand, the challenging style of questioning used in courts may make people with learning disabilities appear to be unreliable witnesses and also result in disempowerment.

Willott et al. (2004) noted that certain types of psychological interventions could jeopardise the integrity of the trial by leading others to question the reliability of the evidence. They referred to the Home Office, Crown Prosecution Service, and Department of Health (2002) joint guidance report, which advised that therapists should avoid the use of interpretative psychodynamic psychotherapy, gestalt work or group therapy before an individual goes to trial. Therefore, clinical psychologists would need to consider what interventions or treatment could support the individual whilst maximising the trial integrity (Willott et al. 2004).
Provision of Psychotherapy

Some survivors of sexual abuse may benefit from one-to-one therapy to work through the emotional reactions to the abuse (Tharinger, Horton, & Millea, 1990). Brown (1993) suggested that people with learning disabilities who have been sexually abused need support to deal with their experiences and to prevent the need to act out what has happened to them. Clinical psychologists may be able to offer a range of different therapeutic interventions. This may involve adapting approaches used with adults and children without learning disabilities, although consideration needs to be given as to how appropriate this may be.

Psychotherapy may focus on the process of recovery, for example RESPOND, an organisation that provides psychotherapy for people with learning disabilities who have been sexually abused, consider the experience of the survivor in terms of a mourning process. They highlight the importance of providing the individual with a safe and containing space to work through the difficult emotions that may be evoked in individuals who experience sexual abuse (Corbett et al. 1996). Other individual treatments might utilise cognitive behavioural strategies such as guided visualisation to recall the abuse, relaxation, monitoring of emotions, distraction, and anger management (Moss, 1998). O’Callaghan et al. (2003) found that often people with learning disabilities wait a long time to receive specialist psychotherapy and that other means of alleviating distress may need to occur whilst an individual is waiting. Clinical psychologists may therefore have a role in providing treatment to alleviate distress before more specialist psychotherapy is obtained, or may have a role in providing this specialist psychotherapy. Other approaches may be solution-focused brief therapy, which is a short term intervention based on clear, structured and practical tasks to facilitate ‘safe remembering’ and restructure negative concepts to empower the individual to regain their quality of life (Cooke, 2003).

Group work is another potential therapeutic intervention. Elliott (1997) found that adult survivors of childhood sexual abuse valued the opportunity to be with other people who had experienced abuse and also the chance, but not the expectation, to share their story with other group members. Groups may also focus on improving
self-esteem, reducing anxiety and teaching assertiveness skills to prevent future abuse (e.g. Barber, Jenkins & Jones 2000). Clinical psychologists may have a role in providing group psychotherapy that focuses on reducing an individual’s vulnerability to future abuse, provides a supportive environment to talk about abuse and the emotions individuals may experience, and opportunities to learn coping strategies to deal with the psychological impact of abuse.

**Indirect work with the individual’s support network**

Moss (1998) suggested that if individuals are in a supportive environment, they often progress through the stages of recovery from sexual abuse naturally. Clinical psychologists may be able to help staff and carers support the individual and provide this environment. Furthermore, clinical psychologists may be able to support staff indirectly through supervision.

*Increasing carers/staffs knowledge and understanding*

Clinical psychologists may be able to provide training for staff or carers to increase their knowledge and understanding of sexual abuse and its impact. They may be able to share information with staff, families and carers in an understandable format (Moss, 1998). This may involve providing staff with information about the range of different responses to sexual abuse and how underlying ‘hidden’ emotions can be translated and expressed through behaviours (Moss, 1998). Clinical psychologists may also provide staff with information about the potential psychological impact of abuse (e.g. PTSD and depression) and the signs and symptoms to be aware of (Sequeira & Hollins, 2003).

Clinical psychologists may also have a role in helping staff and carers understand the process of recovery (Moss, 1998). Information could be shared about different models of recovery and advice given on how to support individuals through this process. This may help staff understand the individual’s experience and enable them to provide the appropriate supportive environment to facilitate recovery. If the individual was receiving one-to-one therapeutic work the clinical psychologist might
help staff understand the possible reactions to expect during the course of therapy (Cooke, 2003).

Clinical psychologists should be aware that cultural, familial, and ethnic values will impact upon an individual’s and staffs’ willingness to discuss issues surrounding sexuality including abuse, and opinion about what is acceptable and unacceptable sexual activity. Furthermore, it is important to consider gender differences when working therapeutically with people with learning disabilities, especially in relation to how they cope with sexual abuse, (Beail & Warden, 1995).

Supporting staff/carers with the discovery that sexual abuse has occurred

O’Callaghan et al. (2003) found that parents and siblings of people who have experienced abuse were also deeply affected, and little support was offered to the families of survivors of abuse. Siblings were reported to experience feelings of stress and parents battled with feelings of guilt for not recognising what was happening to their son or daughter, and anger towards the services in which the abuse had occurred, (O’Callaghan et al. 2003). Another role of a clinical psychologist might involve assisting staff, carers and family members to deal with their own emotions as a result of the discovery that a person they care for has been sexually abused.

Supervising other professionals working with people with learning disabilities

The importance of receiving supervision when working with individual’s who have been sexually abused has also been acknowledged (e.g. Corbett et al. 1996). Clinical psychologists may be able to provide supervision to other professionals, and other clinical psychologists. This supervision may involve providing help and guidance in relation to interventions or through increasing individual’s knowledge and understanding. Importantly though, supervision is necessary to ensure that personal issues do not hinder the process of therapy (Corbett et al. 1996). Clinical psychologists may be able to help other professionals attend to issues of transference and countertransference within the therapeutic relationship which are particularly important when working with individuals who have been sexually abused. Babiker
(1993; cited in Short, 1996) highlighted that there is a need for specialist supervision to be separate from the general regular supervision of clinical work.

**PREVENTION**

The prevention of sexual abuse of people with learning disabilities is an important focus for all professionals. A clinical psychologist may assist in the prevention of abuse through individual work with people with learning disabilities to reduce their vulnerability to sexual abuse, work with staff and carers, and through work with men with learning disabilities who sexually abuse others. Additionally, clinical psychologists could assist with the prevention of abuse by evaluating current approaches to training of both staff and people with learning disabilities.

**Work with individuals to reduce vulnerability to sexual abuse**

*Increasing sexual knowledge*

Lumley & Miltenberger (1997) have drawn attention to the need to increase the sexual knowledge of people with learning disabilities, in order to help prevent sexual abuse. A clinical psychologist may work jointly with other professionals in implementing such programmes. This role is not exclusive to clinical psychologists, and in the author’s experience this is often conducted by other professionals (e.g. Community Nurses), however clinical psychologists may be involved in their development or as co-facilitators.

Clinical psychologists should be respectful of any possible experiences of sexual abuse that people attending the training may have experienced, when delivering sex education to people with learning disabilities (Corbett et al. 1996). Also, the trauma of any abuse may be re-evoked during an in-depth exploration of sexuality or sex education. Furthermore, some cultures and families may feel uncomfortable with their sons or daughters receiving sex education. Miles (1996) described some of the differences between the Western values and the values of Muslims living in Pakistan, and highlighted that this has resulted in a focus on ‘modesty education’ as opposed to
sex education. Cultural differences may also exist in people’s acceptance of the reality that people with learning disabilities are sexual beings and are vulnerable to sexual abuse, (Miles, 1996).

**Increasing self-protection skills**

In order to protect oneself from sexual abuse, individuals with learning disabilities may need opportunities to learn and practise these skills. Lumley and Miltenberger (1997) suggested that these protective skills include the ability to recognise potentially abusive situations, the ability to respond to abuse by refusing or escaping the situation, and the ability to report the abuse. McCarthy (1993) highlighted that women with learning disabilities need to be empowered to “recognise sexual exploitation and abuse and not to tolerate it” (pp. 284). Research had found that following behavioural skills training, individuals were able to utilise the new skills in role play situations but were not as able to use the new skills in naturalistic settings (Lumley, Miltenberger, Long, Rapp & Roberts, 1998; cited in Miltenberger et al. 1999). A later study by Miltenberger et al. (1999) found that in situ training in addition to the behavioural skills training can help individuals to generalise their new skills to naturalistic situations. Increasing self-protection skills through behavioural skills training could also be conducted with children with learning disabilities (Wurtele, 1990; Martorella & Portugues, 1998).

Clinical psychologists may also work with people with learning disabilities to improve their assertiveness skills to help them resist abuse. Singer (1996) described an evaluation of a self-protection group for clients living in a residential group home, which focused on teaching clients to respond appropriately and assertively in situations of abuse.

Clinical psychologists may also have a role as advocates for people with learning disabilities whom they are working with to help them to negotiate aspects of care such as the right to privacy and confidentiality, gaining control and choice (Moss, 1998). To prevent ongoing abuse, clinical psychologists may need to be prepared to ‘think the unthinkable’ (Sinason, 1989), through accepting that this does occur, and being
aware of the potential signs and symptoms of abuse whilst working with people with learning disabilities, especially with individuals who cannot communicate verbally. This may include being willing to ask about abuse, and prepared to listen and believe what the individual says is happening to them, (Brown, 1997). Kit-shan Lee and Sokum Tang (1998) highlighted that cultural values may impact on an individual’s willingness to disclose sexual abuse, and described how the suppression of sexuality in Chinese culture may make discussion and disclosure harder. These cultural differences will need to be considered when working with individuals.

**Work with support staff and carers**

Hogg, Campbell, Cullen and Hudson (2001) highlighted that attempts have been made to enhance staff knowledge of sexual abuse and attitudes through a variety of different forms of training (e.g. Brown, Hunt & Stein 1994); Hames, 1996). These training programmes may involve providing staff/carers with information about why people with learning disabilities are more vulnerable to abuse, how to respond if abuse is suspected and practises that are likely to minimise abuse, (Hogg et al. 2001). Whilst beyond the scope of the present essay to discuss these training programmes in detail, clinical psychologists may have a role either in implementing training of staff and carers or supporting other professionals to implement and design training programmes.

White, Holland, Marsland and Oakes (2003) highlighted aspects of the environment that increase vulnerability to abuse, including staff training and competence, power issues, isolation, lack of opportunities to make choices and a misapplication of the concept of choice. Clinical psychologists may have a role in promoting cultures that are more protective of people with learning disabilities, and communicating this to staff and carers in an understandable format.

McCarthy and Thompson (1995) suggested that it was not uncommon to still hear staff or professionals talk about how women with learning disabilities enjoy sexual or physical violence from men, or that abuse within relationships is not ‘real’ abuse. The author appreciates that this was written nearly 10 years ago, but suspects that some
People with Learning Disabilities Essay

people may still share these outdated views. Opportunities for staff to talk about their own views of sexual abuse and the sexuality of people with learning disabilities and to hear alternative views that challenge these may assist with the prevention of abuse by changing staff's perceptions and attitudes. Clinical psychologists may be able to facilitate opportunities where these views could be challenged in a safe and unthreatening manner. Hames (1996) found that training alone was not an effective way of changing staff attitudes and behaviour, especially in relation to attitudes about the risk posed by staff members. The research found that personal experience was more effective, and "only when the 'unbelievable' occurs can workers 'think the unthinkable'”(pp. 548). This highlights the potential limitations in training as a way of changing staff attitudes.

Working with men with learning disabilities who abuse

Brown et al. (1995) reported that men with learning disabilities were the highest group of perpetrators (53%) of sexual abuse of people with learning disabilities. Clinical psychologists may assist with the prevention of abuse by working with male perpetrators of abuse, to prevent future abuse. This may include assessment of sexually abusive behaviours and interventions. Men with learning disabilities who abuse are often responded to inconsistently when sexually inappropriate behaviour occurs (McCarthy, 1993). Clinical psychologists could work with these individuals to enhance their understanding of sexually appropriate and inappropriate behaviour, or may work with staff to help them understand or implement interventions where the individual receives clear messages about what is appropriate and inappropriate behaviour. Brown, (1997) highlighted that clinical psychologists may provide cognitive treatment related to sexual offending. Other options might include group work for male sexual offenders with learning disabilities which could involve education about the laws and social rules relating to sexual behaviour, (Charman & Clare, 1992).

Clinical psychologists may work with staff to challenge the view that sexually abusive behaviours are out of the individual's control (Brown & Thompson, 1997). Work might include discussion of possible explanations for the men's behaviour, for
example considering whether the sexualised behaviour may be a result of poor attachment, previous abuse and disrupted relationships (Brown & Thompson, 1997).

When working with men with learning disabilities who exhibit sexually abusive behaviours, clinical psychologists may try to conceptualise the abuse using models such as the cycle of offending (Wolf, 1984; cited in Barlow, 2003) or the four factor framework (Finkelhor 1986; cited in Barlow, 2003). Although beyond the scope of the present essay to discuss these further, these models highlight how therapeutic work could focus on breaking the pattern of offending.

**Evaluation of training programmes/groups**

Clinical psychologists may have a larger role in the evaluation of training programmes. Lumley and Miltenberger (1997) described some of the complexities of evaluating these programmes and highlighted that knowledge acquisition should not be the only measure of success as it is important to measure the skills individuals actually utilise in situations. The use of role plays or in situ assessments could be used to measure this, but there are ethical concerns with simulating sexual abuse lures in role plays or in actual situations, (Lumley & Miltenberger, 1997). Little research has been conducted into whether there are any negative effects of increasing sexual knowledge. Consideration is also required into whether prevention programmes designed for use in Western societies can be generalised to individuals from other populations. Kit-shan Lee and So-kum Tang (1998) evaluated a Western sexual abuse prevention programme for female Chinese adolescents with mild learning disabilities and found that a modified behaviour skills training program was effective.

**CONCLUSION**

The author has initially described the potential role of a clinical psychologist in the assessment and treatment of people with learning disabilities who have been sexually abused. This has involved discussion of a variety of different roles that a clinical psychologist may have, which would clearly be dependent upon the individual's situation and needs. Furthermore, the individual's level of learning disability and
cultural background will affect how assessment, treatment and prevention work will be conducted. With such a range of potential areas of involvement, role singularity when working with people with learning disabilities who have been sexually abused is especially important (Moss, 1998). Specifically, a clinical psychologist could be expected to be involved in both the investigation of the allegation of abuse and then expected to work therapeutically with the survivor, two roles which would clearly result in a conflict of interest. Discussion also highlighted that clinical psychologists can assist in the prevention of sexual abuse in a variety of different ways. Finally, there is a need for further research to be conducted into how to effectively assess, treat and prevent sexual abuse in people with learning disabilities.
REFERENCES


Child and Family Essay

"Divorce is bad for children". Critically discuss with reference to the literature on the psychological effects on children of divorce and parental conflict.

Year 2: December 2004
INTRODUCTION

In this essay I will show that the statement “divorce is bad for children” is a simplistic conclusion that ignores the disparate findings documented in research, and the research which investigates whether divorce may be beneficial when releasing children from marriages with high parental conflict. I will initially look at some of the research into the psychological effects of divorce on children. This will include a brief summary of the main influential studies and perspectives from researchers who have contributed a great deal to the literature into divorce. This will be followed by description of the many different factors that could influence children’s adjustment to divorce and discussion of a stress framework for understanding the impact of divorce and parental conflict. I will then look at the research into the impact of parental conflict on children in continuously married families and research into how children’s psychological well-being is affected by levels of parental conflict prior to divorce. Finally, I will briefly describe some of the research which has looked at the psychological effects on children of post-divorce conflict. I conclude that divorce is a complex process involving a number of factors before, during and after separation. Divorce may increase children’s risk of developing psychological problems or other difficulties, dependent on a number of factors, but the majority of children are resilient to this. Divorce appears to have more negative consequences for children from low-conflict families, but can be preferable to remaining in a family where parental conflict is high.

I felt it was important when writing this essay to reflect on my own family background and perspectives on divorce and family conflict. There is a history of continuous marriage within my family and in my experience low parental conflict. I was aware that I may be more likely to relate to the benefits of being in an intact family. However, I was drawn to this essay as I thought that the statement “divorce is bad for children” masked a more complex understanding of the effects of divorce on children.
Divorce rates

The divorce rate in the United Kingdom increased quite substantially between 1961 and the early 1990's, reaching a peak in 1993 of 14.2 divorces per 1,000 married people (Rodgers & Pryor, 1998). Over recent years the number of divorces recorded has fluctuated. In 2003 the number of recorded divorces increased by 3.7% since 2002 to 166,700. Of these individuals, 83,809 had children and thus divorce affected 153,527 children in 2003 (Office for National Statistics, 2004). The majority of these children will be living with their mothers and most will have experienced a number of changes to their living conditions (Rodgers & Pryor, 1998). These statistics are likely to underestimate the number of children who are experiencing parental separation as they are based on divorce rates and do not include co-habiting parents or families where separation as opposed to divorce has occurred.

King (1992) defines divorce as "the legal action that dissolves a marriage and determines custody of children, visiting rights of the non-custodial parent, division of property, and child support" (p. 1009). Most research now considers divorce as a complex process that begins often many years before the dissolution of marriage and continues for many years after this separation. It examines adjustment to one-parent households, remarriage, step-families and second divorces (Furstenberg & Kiernan, 2001).

**Psychological effects of divorce on children**

_Perspectives on divorce_

An overwhelmingly large amount of research has been conducted into the psychological effects of divorce on children. I have become aware whilst reading the literature for this essay, that the research indicates that whilst divorce may have negative effects for some children this is not a universal outcome. Debate focuses on the considerable resiliency of children and the magnitude of differences found between children from divorced families and those from non-divorced families, rather than whether they do in fact exist (Hetherington, 2003). Most researchers agree that divorce is a process that inevitably leads to a number of changes in children's lives.
which may well be stressful. Furthermore, research continues to examine what other factors prior to, during and after divorce might account for these outcomes.

Judith Wallerstein, an influential psychologist from America, conducted early qualitative research into the long-term psychological effects of divorce on children and their parents. This research looked at a sample of 131 children from 60 families classified as white middle-class (Wallerstein & Lewis, 2004). Considerable information was yielded during this research, of which only a small amount can be summarised here. Importantly, Wallerstein presented a particularly negative outlook for the psychological well-being of children following divorce both in the short-term, and into adulthood (Wallerstein & Kelly, 1980; Wallerstein & Lewis, 2004). She reports on the changes that children have to negotiate, often including relocation, disruptions and losses in their friendships, adjustment to contact with parents, and diminished parenting at a time when they needed their parent’s support the most (Wallerstein & Lewis, 2004). Wallerstein and Kelly (1980) reported that 5 years after divorce one-third of the children in the sample were clinically depressed, experienced difficulties maintaining friendships, were having chronic problems such as sleep disturbances and were doing poorly at school. She also reported that 10 years after divorce, most of the children had developed into “troubled youth prone to psychological distress and anxious about forming relationships” (Amato 2003; pp. 333). Wallerstein recruited a comparison sample for the 25 year follow-up from the same community, and concluded that the findings “highlight the unexpected gulf between growing up in intact versus divorced families” (Wallerstein & Lewis, 2004; pp. 353).

A main criticism of Wallerstein’s research is her implication that negative outcomes are a direct result of divorce. Furthermore, Wallerstein’s methodology has been criticised widely by a number of authors (e.g. Elliott, Ochiltree, Richards, Sinclair, Tasker, 1990; Kelly and Emery, 2003). Kelly and Emery (2003) summarised these concerns. They highlighted that the study was qualitative, used a clinical sample, did not have a comparison group from the outset, and did not include standardised and objective measures of psychological adjustment. Therefore, Wallerstein’s conclusions need to be considered within the context of these limitations. However, her research is
unique in the sense that it is qualitative and has yielded a great deal of information about individual's experience of divorce which is extremely rich in detail.

In comparison to the qualitative study described above, a great deal of quantitative research has been conducted comparing children from divorced families and children from continuously married families. Amato and Keith (1991) and Amato (2001) commented on the often contradictory nature of the research into the outcomes of divorce on children. They conducted a meta-analysis to clarify the disparate findings and provide an estimate of the impact of divorce on child well-being across the available studies. They found that children from divorced families scored lower on a number of outcomes, including academic achievement, conduct, psychological adjustment, self-concept, social adjustment, mother-child relations and father-child relations. Amato and Keith (1991) found that effect sizes were reduced when studies used more sophisticated methodology, for example, controls for other confounding factors, larger sample sizes and for sophisticated analyses. Overall, they concluded that whilst children of divorced families scored lower on a number of outcomes (mean effect size = - 0.08 for psychological adjustment) these effect sizes were only of a moderate to weak strength. Thus, this indicated that children from divorced families scored approximately one tenth of a standard deviation lower than children from continuously married families on the domain of psychological adjustment. They suggested that this finding does not support the view that others (e.g. Wallerstein) hold that divorce has profound negative effects on children.

Mavis Hetherington has also conducted a large amount of research into divorce and other marital transitions (e.g. Hetherington, Cox & Cox, 1985; Hetherington 1993). She acknowledges that there is general agreement that children in divorced families are at an increased risk for the development of psychological, behavioural and social problems than those from intact families. She further adds that this risk is greatest for children who have experienced lots of marital transitions, such as remarriage and second divorces. Her main focus however is on the observed resiliency in children (Hetherington, 2003). She emphasises the finding from her own quantitative longitudinal work that 75-80% of children from divorced families function in the normal range with many functioning above this level. Hetherington, Bridges and
Insabella (1998) emphasise a transactional model of risks associated with marital transitions. They conclude that divorce and remarriage increase the probability of parents and children experiencing a number of inter-related risks. They further add that these risks are linked, interact and are mediated and moderated in complex ways. Specifically, they emphasise the importance of individual characteristics of the child and parents, stressful life experiences, parental distress, social support, and family composition (Hetherington et al 1998).

A criticism of the American literature into divorce and other marital transitions has been the tendency to polarise the opinions of Judith Wallerstein and other researchers who have used more quantitative approaches, especially Mavis Hetherington. Amato (2003) has tried to reconcile these views by acknowledging the flaws of Wallerstein’s work and suggesting that the quantitative research supports a more “moderate” version of Wallerstein’s claims. This moderate version suggests that divorce is a risk factor for social and psychological problems and can have negative effects for some but not most children. He also highlighted that Wallerstein et al. (2000 cited in Amato, 2003) acknowledged that divorce is not bad for all children and that some children in intact families experience similar problems. I would agree with Amato (2003) in that the qualitative nature of Wallerstein’s research, the clinical sample used and the intentional focus on what can go wrong when parents divorce, combined with her writing style which is extremely emotive has meant that her findings are often seen to be extreme and lacking in scientific validity.

**Important Factors**

Research into the psychological effects on children of divorce has looked at a number of factors. This has included research into individual factors such as the age of the child at the time of separation (e.g. Walczak & Burns, 1984; Amato & Keith, 1991); gender (e.g. Guidibaldi & Perry, 1985; Amato & Keith, 1991); and the temperament of child (e.g. Hetherington, 1989). Research has also come to see divorce as a process rather than a static event and therefore factors that occur prior to and post-divorce are also important. Thus, research that aims to investigate the long-term consequences of divorce will be confounded by events that occur after divorce that may be associated
with this process. This has led to considerable research into marital transitions occurring after divorce such as remarriage, step-families, second divorces (e.g. Hetherington et al. 1998). Furthermore, as Hanson (1999) emphasised, explanations for the association between divorce and child well-being have emphasised the importance of factors that are a consequence of the divorce transition such as loss of income, family stress, father absence and diminished parenting. Other explanations have looked more at how family processes prior to divorce may impact on child development (Hanson, 1999).

Stress Frameworks

Many researchers have described different theoretical perspectives to explain how divorce affects children. One perspective that has linked divorce and parental conflict suggests that the negative effects of divorce are related to a number of stressful situations prior to, during and after divorce. The stress perspective views divorce as a process that begins whilst parents are living together, and that divorce can set a number of events into motion that are stressful for children (Booth & Amato, 2001). This implies that divorce may be bad for children as it exposes them to a number of stresses that children from non-divorced families would not face.

In order to discuss the statement “divorce is bad for children” it is important to consider situations in which divorce may be a preferable option to remaining married. The family stress perspective suggests that some divorcing families may have experienced stress prior to the divorce, often as a result of parental conflict (Booth & Amato, 2001). Research has therefore looked at whether the negative outcomes associated with divorce are actually due to parental conflict prior to the divorce (Hanson, 1999). Research has also investigated whether divorce may benefit some children, by providing them with an escape from an unhappy or conflictual family situation (Hetherington, 2003). To support this, some research has found that children’s difficulties previously assumed to be a consequence of divorce, were actually present a number of years prior to the separation (Block, Block & Gjerde 1986; Cherlin et al, 1991; cited in Kelly & Emery 2003). Block et al. (1986; cited in Kelly & Emery, 2003) found that children from divorced families had high levels of
aggression, hyperactivity, impulsivity, anxiety, and emotional problems as much as 11 years prior to the divorce. Furthermore, researchers have also noted that two-parent married families may not offer children a happy environment (Kelly & Emery, 2003; Davies & Cummings 1994; Amato, Loomis & Booth, 1995) and parental conflict has a large impact on children's psychological well-being. Block et al. (1986) therefore suggested that high levels of parental conflict during the marriage could explain these findings. This led some researchers to speculate as to whether a stable home in which the parents are divorced is better for a child than a home where the parents remain together but high levels of conflict remain (Hetherington, 1979).

Psychological impact of parental conflict on children

In this section I am going to look at some of the theoretical perspectives that have been provided for why parental conflict may have a negative psychological effect on children. I will then discuss the research that has been conducted into parental conflict and divorce. This will look at whether the negative outcomes of divorce are a result of parental conflict prior to divorce, and how the level of parental conflict prior to divorce may determine whether or not divorce is perceived as good or bad for children. Finally, research into the impact of parental conflict after divorce as a continuing stressor for children will be discussed briefly.

Theoretical perspectives

Amato et al. (1995) suggest that there are several mechanisms through which parental conflict might have both short and long term psychological effects for children. Specifically, they emphasise that parental conflict is a direct stressor for children. Cummings and Cummings (1988; cited in Davies & Cummings, 1994) also suggest that the stress of parental conflict may have a psychological impact on children. Studies observing children's reaction to conflict have shown that children show fear, anger, aggression or the inhibition of behaviour (Cummings, Zahn-Waxler & Radke-Yarrow, 1981; cited in Amato et al., 1995). Another explanation suggests that children's behaviour may be influenced by parental conflict through the process of modelling (Hanson, 1999). That is, behaviour problems in children may be a result of
children modelling their parents aggressive behaviour observed during conflict. 
Davies and Cummings (1994) emphasised how parental conflict has negative 
psychological effects for children through impacting on children’s emotional security 
and attachment relationships. Grych and Fincham (1990) describe how parental 
conflict may affect children indirectly by deterioration in parent-child relationships. 
Emery (1982) also commented that parental conflict may result in inconsistent 
parenting or negative parenting. Thus, a variety of different theoretical perspectives 
suggest how parental conflict may have negative psychological effects for children, 
which I feel are similar to some of the perspectives provided for why parental 
separation may negatively impact on children.

Research into parental conflict in divorced and intact families 

Research has found that parental conflict has negative consequences for children 
(Jekielek, 1998). Specifically, research emerged which suggested that whilst divorce 
may affect children psychologically, parental conflict in married families also impacts 
on children’s psychological well-being. Emery (1982) presented a qualitative review 
of research and suggested that high levels of conflict between parents who remained 
made can increase the risk of children experiencing psychological problems. 
Furthermore, the meta-analysis completed by Amato and Keith (1991) found that 
children in families whose parents remained together but experienced high parental 
conflict showed significantly lower scores on psychological adjustment measures and 
self-esteem, than children from divorced families. This early research often did not 
look directly at parental conflict, or relied on retrospective measures which are 
potentially biased (Jekielek, 1998). Furthermore, these studies did not look at the 
impact of levels of parental conflict within divorced families. Longitudinal studies 
incorporating measures of pre-divorce conflict were necessary to investigate this 
further.

Cherlin et al. (1990; cited in Amato et al. 1995) used a British longitudinal data set of 
11,000 children. They found that differences between boys from divorced and intact 
families reduced to non-significant when pre-divorce differences and family conflict 
were included. They interpreted this as parental conflict being associated with the
child’s well-being rather than divorce. On the other hand, their results suggested that for girls divorce and parental conflict appeared to have independent effects. However, the Cherlin et al (1990) study only used a short measure of family conflict (2 items) which was rated by a Health Visitor and combined with other variables hence making it hard to assess the independent role of conflict (Amato et al. 1995).

Improving on this research, Amato et al. (1995) used data from a 12 year longitudinal study to investigate how parental conflict and divorce are related to offspring’s well-being in early adulthood. They interviewed parents on four occasions between 1980 and 1992. At the last interview they also interviewed 471 adult offspring. They separated these children into those who had experienced their parents divorce after 1980 and those whose parents remained together. This resulted in 42 individual’s in the divorced group, a relatively small sample. Parental conflict scores were taken at each interview and involved parental reports of the severity and amount of verbal and physical conflict. The parental conflict measure was taken from the interview data set occurring before the parent’s divorce (e.g. parental divorce in 1982, data taken from 1980 measures). Amato et al. (1995) found that when parental conflict is high, the psychological effects are lower if parents divorce than if they remain married. Furthermore, they found that when parental conflict is low pre-divorce, the psychological effects of divorce are higher if parents divorce than if they remain married. An interesting finding from this study was that young adults whose parents divorced from a high-conflict marriage were doing as well in adulthood as children from low-conflict intact families.

To explain this finding Amato et al. (1995) draw on the work of Wheaton (1990) who found that the consequences of life transitions on mental health are dependent upon the level of stress prior to the transition. Thus when stress is high, a transition provides relief from this stress, where as when stress is low children may not be prepared for or see any benefits of divorce. As already mentioned the sample of individuals from high-conflict marriages ending in divorce is particularly small and therefore these findings need to be supplemented by further research.
Jekielek (1998) builds on the work of Amato et al. (1995) looking at the interaction between parental conflict and divorce on children's psychological well-being. The children in her study were between the ages of 6 and 14 at the time of the fourth and final data collection point in 1992. The measures of parental conflict included measures of the frequency and the variety of topics argued about. She found that both parental conflict and divorce increased later anxiety and depression levels in children. She concluded that the "benefit of an intact family status for child anxiety and depression decreases as conflict increases" (Jekielek, 1998; pp. 930). Her results also found that the impact of divorce remained significant after parental conflict was controlled for, suggesting that parental conflict does not account for all differences observed between divorced and intact families. Her results also supported the interaction effect found by Amato et al. (1995) that children from high-conflict marriages appear to benefit from divorce as compared to children where there is high-conflict and the parents remained together.

Whilst Jekielek looked at anxiety and depression (internalising behaviours), Morrison and Coiro (1999) looked at the interaction between parental conflict and divorce on behaviour problems in young children of an average age of 6. In their study they found that divorce had a negative effect on children's behaviour problems and that prior report of high levels of parental conflict increased behaviour problems. They also found that parental conflict did not explain all of the negative effects of divorce on behaviour problems. Specifically, they found that behaviour problems increased following divorce regardless of the level of parental conflict. They did find support for the hypothesis that children remaining in high conflict marriages experience the greatest increase in behaviour problems, but did not provide support for the hypothesis that divorce in a high conflict marriage will have a stress-relieving impact on children. However, it may be that behaviour problems increased while other aspects of psychological functioning remained the same or improved. Furthermore, it could be suggested that the benefits of leaving a high-conflict environment may not be apparent until later in a child’s life (Morrison & Coiro, 1999).

Booth and Amato (2001) also found that divorce in low-conflict marriages appears to have negative effects on children's psychological well-being where as divorce from
high-conflict marriages may be beneficial. Their study included a larger sample size (85 children) and a wider range of outcome measures including assessment of individual’s kin and peer support networks, the quality of intimate relationships, and educational attainment in addition to psychological well-being. Therefore, the research described above suggests that parental conflict explains some but not all of the negative outcomes associated with divorce. Furthermore, the results indicate that divorce may be bad for some children, especially if parental contact prior to divorce is low. However, divorce may be a preferable option to remaining together when parental conflict levels are high. This does not however mean that divorce from a high-conflict family is not a painful and distressing experience for children (Inglis, 1982).

A limitation of Jekielek’s (1998) and Morrison and Coiro’s (1999) research is the narrow measure of parental conflict utilised in the study. This was because the data for both studies were drawn from a National Longitudinal Survey of Youth which gathered data on a range of areas. The measure of parental conflict just looked at frequency and content of conflict and the measure was a rating from the mother only. Ratings from the partner, child or an independent observer would ideally provide a more valid measure of parental conflict (Jekielek, 1998).

Bryner (2001) reflected upon the unexpected finding reported in many of the studies described above, that children from low-conflict families experience more negative adjustment problems when their parents divorce than children from high conflict marriages. This finding has helped me to think about my clinical work from a different perspective. I am currently working with a 12 year old boy who was referred due to behaviour problems and aggressive and violent behaviour towards his mother. During the initial assessment with him and his parents, who separated when he was 3 years old, he told us that he wishes his parents would get back together. Discussions with his parents revealed that the marriage had ended amicably without any overt conflict. Furthermore, there has been no post-divorce conflict and he spends equal amount of time with each parent. We wondered whether the absence of parental conflict both before and after the separation has meant that he finds it hard to understand why his parents are separated. Furthermore, he may also blame himself or
feel responsible for his parent’s failed marriage as he may not understand why they are separated. One possible hypothesis for his behaviour is that it serves the function of bringing his parents together.

*The importance of conflict resolution*

The studies described above have only looked at the frequency and content of parental conflict. Another factor that might impact upon the psychological effects of parental conflict on children is how conflicts are resolved between parents. Hanson (1999) extended the research described above to include a question about conflict resolution. However, he combined this into a general measure of parental conflict, therefore not enabling further exploration of whether conflict resolution may impact on the effects of conflict on children. Research which looked at the impact of parental conflict on children in continuously married families has looked at conflict resolution. Grych and Fincham (1990) suggested that children may benefit from observing parents who successfully resolve conflict as this may provide children with a positive model of problem-solving. Davies and Cummings (1994) describe 11 studies which have looked at conflict resolution and suggest that successful resolution of conflict reduces negative reactions to parental conflict and suggest that this is due to increasing emotional security. Furthermore, as Davies and Cummings (1994) suggest, conflict within families is a normal part of life and may need to occur if important issues are to be resolved. It might be that exposure to constructive conflicts and resolution may teach children effective ways of dealing with conflict during their life. However, research has only looked at the short-term reduction in distress observed in children after a conflict and then subsequent resolution. This does not look at whether differences exist between children in the long-term as a function of the parent’s ability to resolve conflict. I feel that further research into this area would be beneficial in understanding how parental conflict may lead to negative psychological effects in some but not all children.

**Impact of parental conflict post-divorce**

Bryner (2001) suggested that when divorce fails to reduce the high parental conflict occurring this may place additional stresses on children. He described this as a “failed
divorce” and emphasised the importance of parents developing a relationship post-divorce that avoids continued conflict. Kelly and Emery (2003) suggest that persistent conflict post-divorce is a major stressor for children. They highlight, however that evidence into the impact of post-divorce conflict is mixed. Amato and Keith (1991) conclude that less conflict and greater cooperation predicted better adjustment and fewer problems among children. Similarly, Hetherington (1999; cited in Kelly and Emery, 2003) suggested that post-divorce conflict has more adverse effects than conflict in married families. Booth and Amato (2001) on the other hand, found that post-divorce conflict was not associated with adjustment problems in adulthood, and suggest that pre-divorce conflict is a better predictor of children’s psychological well-being post divorce. Kelly and Emery (2003) suggest that these differences may be a result of the different measures of conflict used in studies and a failure to differentiate between different types of conflict, the amount of exposure to this conflict and resolution styles. Currently, there is a need for more research into parental conflict post-divorce.

Diversity Issues

The findings described above highlighted that the psychological effect of divorce and parental conflict on children is extremely diverse. It is also therefore likely that ethnic and cultural factors also influence these outcomes. Amato and Keith (1991) suggested from their meta-analysis that studies of divorce conducted on children from countries other than America tended to report more problems with conduct, psychological adjustment and parent-child relationships. However, there were only a small number of studies from different countries included in the analysis and they did not investigate this further. More recently, researchers have started to look at the some of these cultural issues. Gohm, Oishi, Darlington, and Diener (1998) suggested that situational or cultural factors may lessen the adverse effects of divorce and describe their research into differences in societies depending on their divorce rate and whether they are a predominantly an individualist or collectivist culture. Although beyond the scope of this essay to describe this in detail, this research highlighted the importance of considering how cultural factors may protect or increase the risks associated with divorce and parental conflict. Furthermore, Amato (2001) commented on the
“frustratingly rare” amount of research available on racial and ethnic minorities, indicating that this an area that would benefit from further research.

CONCLUSION

In this essay I have looked at the different perspectives and research that has been generated in an attempt to understand the complexity of divorce and the psychological impact on children. Initially, I described some of the different perspectives of the psychological impact of divorce on children and concluded that divorce may be a risk for children as it presents a number of additional stressors for them to cope with. However, the majority of children are resilient to this risk and research has attempted to identify what factors may increase or decrease this risk. I then described research into how parental conflict may explain some of the psychological effects of divorce on children. Furthermore, this discussion revealed that divorce when parental conflict is low is a risk factor for later adjustment problems, where as divorce when parental conflict is high, may be preferable to children remaining in a conflictual environment. Finally, divorce may be bad for some children in the presence of certain risk factors and the absence of protective factors. Therefore, I will conclude that divorce is not always bad for children, and is dependent on a number of different factors of which parental conflict is just one.

Further research is now needed into different interventions and strategies for reducing risks to divorce and increasing protective factors. Given the diversity of responses to divorce within the literature, research into cultural differences as a result of race, ethnicity and religion would increase the richness of research in this area.

I would like to reflect on the struggles I have had approaching and responding to this essay, which I feel may reflect the diversity of research and different factors impacting on children’s psychological well-being, and the complexity of marital transitions. Importantly, this literature has drawn my attention to the risks of divorce and parental conflict and to the resiliency of children.
REFERENCES


What contribution can psychological psychotherapies make to alleviating problems of depression or anxiety experienced by older people? Discuss in relation to two major models of psychotherapy.

Year 2: August 2005
INTRODUCTION

In this essay I will focus on the contribution of psychological psychotherapies in alleviating the problems of depression experienced by older people. I have chosen to focus on cognitive-behaviour therapy (CBT) and interpersonal therapy (IPT) as these two approaches have the largest evidence base at present (Arean, 2004). I am going to assess the contribution of these two approaches by looking at the research which has been conducted into the efficacy and effectiveness of CBT and IPT in reducing symptoms of depression. Firstly I will present prevalence rates of depression in older people and then describe CBT and IPT. I will then look at the research which has attempted to assess the effectiveness of psychotherapies in general and specifically for CBT and IPT. I will look at whether CBT has been found to be effective as compared to no treatment, other psychotherapies and pharmacological treatments. Discussion will then turn to look at the effectiveness of CBT for people with co-morbid illnesses and I will describe the limited research into which older adults will benefit from CBT. The research into whether IPT has been found to be effective in comparison to no treatment and pharmacological treatments will be addressed and research which has looked at whether IPT can be effective in preventing relapse and recurrence of depression. After a brief discussion of some of the limitations of this research I will look at ways of maximising the contribution of psychological psychotherapies.

Prevalence of depression in older people

Prevalence rates of depression within older people suggest a need for effective interventions for this age group. The Department of Health’s National Service Framework for Older People (2001) states that:

“At any one time, around 10-15% of the population aged 65 and over, will have depression. More severe states of depression are less common, affecting about 3-5% of older people.” (pp. 93)

Karel and Hinrichsen (2000) indicate that older people often report relatively high rates of depressive symptoms which do not reach clinical diagnostic levels. Rybarczyk
et al. (1992) found that older adults with chronic illnesses were twice as likely to be depressed as those without. Furthermore, the prevalence of chronic illnesses increases with age to the extent whereby 50-86% of older people over 65 report at least one chronic illness (Rybarczyk et al. 1992). Older people who are disabled by medical illness are at the highest risk for depression (Karel & Hinrichsen, 2000). Despite these prevalence rates, which are comparable to those in the general adult population, many older people are not offered psychotherapy (Murphy, 2000).

In trying to understand why older people might become depressed and seek therapy, Knight (1999) indicates that problems that “threaten psychological homeostasis at any point in the lifespan: chronic illness, disability, the loss of loved ones to death, ...” (pp. 931) are more common in the later stage of life. Therefore, in addition to the usual day to day challenges of life, older people may have additional challenges to overcome. Furthermore, people who have suffered with depression all of their lives eventually become older people who may be continuing to struggle with these problems (Knight, 1999).

MODELPS OF PSYCHOTHERAPY

Cognitive behavioural therapy

CBT is a well-validated psychotherapeutic approach for treating depression within the adult population. Laidlaw (2001) indicates that the most common form of CBT used within the UK is based on the cognitive model of depression developed by Beck, Rush, Shaw and Emery (1979). The cognitive model states that depression is a result of interactions between thoughts, behaviour, emotions and physiological factors (Dick, Gallagher-Thompson & Thompson, 1996). This model suggests that individuals have beliefs about themselves and the world which influences their thinking. This thinking in turn mediates feelings and behaviour (Wilkinson, 2002). Depression is maintained by depressive maladaptive patterns of thinking (Floyd & Scogin, 1998).

CBT is a structured and problem focused approach which combines behavioural techniques (e.g. monitoring and increasing levels of pleasurable activity and
conducting experiments to test out beliefs) and cognitive techniques (e.g. identification and challenging of thoughts and assumptions). Through the collaborative therapeutic relationship, the individual learns strategies to challenge unhelpful patterns of thinking and change behaviours to improve mood.

Laidlaw, Thompson, and Gallagher-Thompson (2004) suggest some additional factors that need to be considered in CBT with older people. This includes exploration of cohort beliefs (shared beliefs and experiences of age-specific generations); consideration of the importance and function of roles carried on or lost as they age; intergenerational linkages (e.g. relationships with older children); the socio-cultural context (beliefs about ageing in the culture and society they live); and the physical health status of the individual and how this impacts on independence and autonomy.

The underlying assumption of CBT is that learning occurs across the lifespan and people always have the potential to change, therefore making it an appropriate approach for older people (Zeiss and Steffen, 1996). Floyd and Scogin (1998) suggest that it is especially important when working with older people to use CB strategies to reduce feelings of hopelessness by addressing beliefs about the possibility of change. They suggest that this should be a priority for CB therapists when working with older people, and highlight how CBT strategies are useful for challenging these beliefs and assumptions.

Interpersonal Psychotherapy

IPT, developed by Klerman et al. (1984) is a brief, focused and structured psychological therapy that has been found to be an effective treatment for depression in younger adults (cited in Hinrichsen, 1999). IPT focuses on interpersonal relationships and was developed from the observations that interpersonal difficulties can precipitate depression, arise for an individual as a result of depression and also persist beyond and impact upon recovery from depression (Hinrichsen, 1999). Klerman et al. suggested that focusing on an individual’s current interpersonal relationships can be an effective way of reducing depressive symptoms. They also found that four interpersonal problem areas account for most of the themes that
generally arise in psychotherapy. These four areas are: unresolved grief; interpersonal disputes (conflicts with a significant other); role transition (significant changes in a life situation); and interpersonal deficits (persons lacking the requisite skills to establish social relationships or maintain them). IPT involves identifying the areas of conflict most relevant to the individual and working on these issues within a time limited number of sessions.

IPT is organised into three phases: a 16 week acute phase of weekly sessions; a 6 month continuation phase of reduced number of sessions aimed to maintain symptom reduction; and a maintenance phase of monthly or bi-monthly sessions for a minimum of 6 months which aims to prevent relapse (Arean 2004). IPT involves focused work on the problem areas identified through discussion of situations and specific events occurring presently that relate to the identified interpersonal area of conflict. A variety of strategies are employed, some familiar to other psychotherapies such as behavioural change techniques and reality testing of thoughts and beliefs, and psychodynamic techniques such as exploration, clarification of affect, and the use of the therapeutic relationship. (Hinrichsen, 1999).

Karel and Hinrichsen (2000) state that IPT “appears especially well-suited for older adults in view of the increasing frequency of death of family and friends, changes in social roles, the need to acquire new or adapt existing social skills to changing life circumstances, and the adverse emotional impact of conflicts with significant others....” (pp. 715)

**RESEARCH INTO THE EFFECTIVENESS OF CBT AND IPT**

Over recent years researchers have completed meta-analyses or reviews of the studies on different psychotherapies effectiveness (e.g. Scogin & McElreath, 1994; Pinquart & Sorensen, 2001; Gatz et al. 1998). Scogin and McElreath (1994) conducted a meta-analysis of 17 studies to examine the efficacy of psychosocial interventions for depression in older adults. The studies compared either a psychosocial intervention to a control (e.g. no treatment) or another psychosocial intervention. They categorised the interventions into cognitive, behavioural, psychodynamic, reminiscence,
interpersonal or eclectic therapies. They concluded that psychosocial interventions were superior to no treatment in reducing depressive symptoms. They did not find any superiority between different types of psychotherapies. Similarly, Pinquart and Sorensen (2001) found significant improvements in client and therapist rated depression measures, and on measures of general well-being when combining all psychotherapies.

The reviews and meta-analyses show that psychotherapy in general is as effective as medication in reducing depressive symptoms. However, the specific contribution of individual psychotherapies and comparisons across psychotherapies is difficult to determine within these reviews due to the differences in research design and methodology.

**Cognitive Behavioural Therapy**

*CBT versus no treatment or other psychotherapies*

The meta-analysis studies provide some evidence for the effectiveness of CBT over no treatment as it was the psychotherapy employed in a number of the studies reviewed. However, a closer look at the research specifically looking at CBT provides further information about the individual contribution of CBT.

Rokke, Tomhave, and Jocic (2000; cited in Arean & Cook, 2002) compared CBT to a wait-list control and found it to be superior both immediately after treatment and over a one-year follow-up period. Thompson, Gallagher and Breckenridge (1987) randomly allocated 91 older people to behavioural, cognitive, psychodynamic psychotherapy, or delayed treatment. They found that participants in all three treatment conditions showed improvement on Beck Depression Inventory (BDI) scores in comparison to the delayed treatment condition, thus providing some support for the effectiveness of CBT in comparison to no treatment. Thompson et al suggest that the recovery rates were comparable to those found in younger adults.
Koder, Brodaty, and Anstey (1996) reviewed seven studies that looked specifically at cognitive therapy based on Beck's therapeutic model, in comparison to another type of psychotherapy. Koder et al. (1996) found cognitive therapy to be more effective than behaviour therapy alone or psychodynamic therapy in three studies. However, three studies failed to find a significant difference between types of psychotherapy. The participants in these studies were below the age of 75 and therefore this cannot necessarily be applicable to older adults above 75, who arguably may also have physical illnesses. A criticism of this review is the huge variations between the studies, in terms of the settings participants were in, the number of sessions attended, and whether this was in a group or individual setting. All of these variables are likely to have impacted upon the outcomes obtained.

Pinquart and Sorensen (2001) found that CBT was more effective than psycho-educational interventions, activity promotion and cognitive training. Steuer et al. (1984) compared CBT in a group setting with psychodynamic group therapy. They found that whilst both psychotherapies resulted in reduction of depression as measured by the BDI and the Hamilton Rating Scale for Depression, CBT was superior to psychodynamic interventions.

Therefore at present, there is evidence for the effectiveness of CBT in comparison to no treatment, but research has not been able to determine if CBT is superior to other psychotherapies. One major limitation of the research into the contribution of CBT in alleviating problems of depression is that few studies have looked at long term effectiveness. The studies which have looked at longer term effectiveness have tended to only look one year post treatment, and have found positive results.

**CBT with pharmacological treatments**

Thompson, Coon, Gallagher-Thompson, Sommer, and Koin (2001) acknowledge that whilst pharmacotherapy has been found to be effective, psychotherapies have a role in addressing the psychosocial factors that might lead to and be a consequence of depression. Thompson et al. highlight that considerable debate remains as to the relative efficacy of pharmacotherapy, psychotherapies and their combination within
the adult population in general. They compared the efficacy of desipramine (a tricyclic anti-depressant which was the treatment of choice at the time of the study), CBT and a combination of CBT and desipramine. The results indicated that combined treatment of CBT and desipramine was superior to desipramine alone. There was little difference between CBT alone and combined treatment. CBT alone and CBT with desipramine were more effective than desipramine alone. On closer inspection of the data, combined treatment was more effective for individuals with more severe levels of depression as measured by the Hamilton Depression Rating Scale. This result suggests that CBT alone may be slightly more effective than desipramine alone, and combining CBT with desipramine may improve the contribution that CBT can make to alleviating problems of depression in older people.

On the other hand, the results from Thompson et al. (2001) should be generalised with caution as participants were mainly under 70 years of age, white, well-educated, experiencing mild-moderate levels of depression, and one-third of participants still had some form of employment. Furthermore, individuals with a co-morbid condition were excluded, thus making this sample less representative than the clinical population of older people normally referred to services. As Thompson et al. (2001) state, further research is needed on heterogeneous groups of older people to encompass ethnic diversity. Finally, current research is needed into the efficacy of selective serotonin reuptake inhibitors (SSRIs) which are the current treatment of choice for depression.

CBT for patients with co-morbid illnesses

The majority of research has included healthy ‘young’ older people (Draper, 2000). Considering the extremely high prevalence of physical illnesses in older people it is difficult to know how applicable the findings are to the clients receiving therapy in clinical practice. It is important to look at research which has specifically included older people with physical illnesses. Kemp, Cogiat, and Gill (1991/1992; cited in Niederehe, 1996) compared the effects of a brief CBT group for older people with and without a disabling illness. The severity of depression for these individuals was equivalent across groups. The results indicated that both groups of individuals
improved on measures of depression and everyday functioning. However, the group of individuals without a disability continued to improve after the group had finished whereas those with a disability did not. It may therefore be important to consider whether older people with a co-morbid disability would benefit from a form of maintenance CBT. Unfortunately, I have not found any studies which have explored this issue further in terms of CBT, but will describe the use of IPT as a maintenance therapy later.

The research conducted by Steuer et al. (1984) provides some further evidence for the effectiveness of CBT for older people with medical illnesses as 90% of the participants were reported to have a co-morbid medical condition. This intervention successfully reduced depression levels in individuals and was superior to a psychodynamic group. However, long term effectiveness was not measured in this study, and there was no comparison group of individuals without a co-morbid condition.

Kneebone and Dunmore (2000) reviewed research on interventions for older people with post-stroke depression and suggested that CBT may be a promising approach and should be explored and researched further. Lincoln and Flannaghan (2003) investigated CBT for post-stroke depression through a randomised controlled trial and found no significant differences between those who received CBT, an attention placebo, and standard care. They suggest that this needs further exploration due to limitations in their study in terms of the number of participants, method of recruitment and selection criteria.

Overall, there is limited research regarding the effectiveness of CBT with older people with depression and physical illnesses. The research is inconclusive with some suggestion that co-morbid illnesses may impact on the effectiveness of CBT and older people with physical illnesses/disabilities may benefit from longer term or maintenance therapy.
Which older people will benefit from CBT?

Gallagher-Thompson and Steffen (1994) compared the effectiveness of CBT and brief psychodynamic therapies in alleviating the problems of depression in 66 clinically depressed family caregivers of frail and elderly relatives. They found CBT and psychodynamic approaches were effective interventions, with 71% of the individuals no longer meeting criteria for depression following treatment. They also found that length of time as a caregiver may be a variable to consider when choosing an appropriate intervention, as older caregivers who had been caring for longer than 44 months, benefited more from CBT than psychodynamic therapy, and the reverse was true for ‘newer’ (less than 44 months) caregivers. It may be that long term caregivers require structured interventions to maintain hope and coping resources which may be depleted as a result of the length of time caring. Newer carers may have benefited from a chance to process changes, accept any losses and adapt to becoming a carer (Gallagher-Thompson & Steffen, 1994).

Leung and Orrell (1993) looked at the efficacy of a brief CBT group intervention for older adults with mood disorders. They found that individuals with a diagnosis of major depressive episode, according to DSM-III-R criteria, showed significant improvement, where as no significant improvements and some decline was found for those older adults with “other mood disorders” (including dysthymia, cyclothymia, bipolar disorder and personality disorder). Unfortunately, the numbers of participants in these groups are small, and this research did not have a waiting list control to compare the groups to. Thompson, Gallagher and Czirr (1988) found that older people with depression who also had a personality disorder, were less likely to benefit from short term treatment. Overall, these findings indicate the need for further research into which older people will benefit from CBT and what adaptations could maximise this effectiveness.
**Interpersonal Therapy**

*IPT versus no treatment*

There is less research into the effectiveness of IPT in alleviating problems of depression for older people (Thompson et al. 2001). Most research has focused on IPT in conjunction with medication or pill-placebo which makes it difficult to evaluate the effect of IPT alone. Referring back to the reviews and meta-analyses on psychotherapies in general, there is some suggestion that IPT is more effective than no treatment, but further research is clearly needed to determine the stand-alone efficacy of IPT. Reynolds et al. (1999) found IPT and a pill placebo to be more effective than pill placebo alone in preventing the recurrence of major depression, but they did not have a no-treatment or IPT alone condition. In clinical practice, it is likely that individuals will receive anti-depressant medication as the first course of treatment and possibly further psychotherapy if available (Murphy, 2000). Arean, Hegel, Reynolds (2001) state that 30% of older people would rather be treated with psychotherapy than medication, so there is a clear need to determine the efficacy of IPT without medication or pill placebo. Arean (2004) concludes that "the pure effect of IPT on late-life depression is relatively unknown" (pp. 50). Furthermore, aside from the meta-analyses which attempted to compare various psychotherapies and found equal efficacy, research has not compared IPT to other psychotherapies. This lack of comparison makes it difficult to determine the relative contribution of IPT to alleviating the problems of depression in older people.

*IPT with pharmacological treatments*

Sloane, Staples and Schneider (1985; cited in Karel & Hinrichsen, 2000) conducted one of the earliest studies into IPT and nortriptyline (a tricyclic antidepressant). Although this was just a small scale study, the results indicated that IPT was as effective as nortriptyline in the acute phase of treatment of older people with major depressive disorder, at six and sixteen weeks. They found that older people receiving nortriptyline were more likely to drop out of the trial than those receiving IPT and suggested that this might be because of the negative side effects of the medication (Karel & Hinrichsen, 2000). Therefore, this research suggests that IPT is as effective
as anti-depressant medication in the acute treatment of major depression and may in fact be beneficial for those individuals who experience side effects to medication or who do not wish to take medication.

Reynolds and colleagues (e.g. Reynolds, 1997; Reynolds et al. 1999) conducted an ongoing study for a period of 7 years, investigating the usefulness of a combined approach of IPT and nortriptyline with older people with recurrent depression. Their study included 180 older people with an average age of 67. All of the participants received open treatment of combined IPT and nortriptyline for the acute period until remission of depressive symptoms (determined by a score of 10 or lower on the Hamilton Depression Rating Scale) was achieved. Participants then progressed to the continuation phase of treatment where they continued to receive nortriptyline and IPT, although the IPT sessions occurred fortnightly as opposed to weekly. This phase lasted for 16 weeks to ensure stability of remission. IPT and nortriptyline in combination successfully resulted in alleviation of depressive symptoms in 78.7% of the participants. These individuals then entered a maintenance phase, which is described below. However, 51% of the participants received adjunctive pharmacological treatment, so it is not possible to determine whether the high success rate would have been achieved for all of these individuals with just nortriptyline and IPT.

IPT as a maintenance treatment for recurrent depression.

Reynolds et al. (1999) highlight the importance of investigating how psychological therapies can contribute to maintaining recoveries made during treatment and preventing relapse or recurrence of depressive symptoms. They point to research which has indicated that the long-term prognosis for depression in older people is poor, and that people over the age of 70 are especially prone to relapses. The main aim of the research by Reynolds and colleagues described above, was to investigate the long-term efficacy of IPT and nortriptyline in preventing relapse in older adults with depression. They studied this by randomly assigning the 124 participants who had successfully completed acute and continuation treatment, to one of four conditions; medication clinic with nortriptyline; medication clinic with placebo;
monthly maintenance IPT with nortriptyline; and monthly maintenance IPT with placebo. During the maintenance phase, participants visited the clinic monthly or until recurrence of depression. Overall, they found that IPT and nortriptyline both individually and in combination, were more effective in preventing relapses than medication clinic visits and placebo. Moreover, they found that IPT and nortriptyline in combination was significantly more effective than medication or IPT alone, with 80% of participants in the combined treatment group remaining depression-free (Reynolds et al. 1999). Medication alone was more effective than IPT and placebo in preventing relapses, hence suggesting that IPT has the largest contribution to maintaining the alleviation of problems of depression when combined with pharmacology. They also found that older people over the age of 70 were more likely to relapse during the first year of maintenance in all conditions except for the combined IPT and nortriptyline condition. Taylor et al. (1999; cited in Arean & Cook, 2002) found that more severely depressed older people were more likely to relapse when receiving IPT maintenance therapy alone, in comparison to those who had combined treatment, nortriptyline alone or IPT with a placebo. Therefore combined treatment might be most beneficial for older people over 70 and individuals with severe levels of depression.

IPT for patients with physical illnesses

Reynolds (1997) found no difference between individuals who had co-morbid medical illnesses and those without in his research looking at the effects of IPT and desipramine. Mossey, Knott, Higgins, and Talerico (1996) evaluated a variation of IPT, interpersonal counselling (IPC) with older people who were in hospital for medical problems, experiencing mild depression (cited in Draper 2000; Karel & Hinrichsen, 2000). They found that at 6 months following the start of treatment, IPC was superior to ‘usual care’ in reducing depressive symptoms. This is one of the only research studies which has looked at the efficacy of IPT as a stand-alone intervention (Arean and Cook, 2002). The finding that a variation of IPT can be effective for older people with mild depression and medical problems is important, but this finding cannot be generalised to more severe depression. It may be that individuals with more
severe depression and medical conditions would benefit from IPT in combination with medication.

**Limitations of research**

I have identified some limitations with the research to date, including the predominant use of healthy, young white older people in the research which may not be representative of the clinical population. In addition to this, there is a lack of research into whether certain types of psychotherapies are effective for certain individuals. Furthermore, the majority of researchers seem to value quantitative research and randomised controlled trials as the best form of evidence. It is beyond the scope of this essay to enter into the debate about the best forms of research, however this is an important limitation of the current research. It would be beneficial for researchers to conduct qualitative research, for example to elicit older people’s views of different forms of psychotherapies. Another limitation of the research is the use of measures that may not be standardised for older people (e.g. BDI), however more recent research uses measures designed for older people and future research should ensure measures are appropriate. Finally, whilst some studies have looked at other measures of well-being, the research tends to focus on reductions on outcome measures for depression. Therefore an incorporation of measures of general functioning and more subjective qualitative feedback would be beneficial.

**MAXIMISING THE CONTRIBUTION OF PSYCHOTHERAPIES**

**Adaptations of therapy to older people**

Arean (2004) indicates that whilst there is no systematic research to suggest that psychotherapies must be adapted and modified for older people, most professionals in the field would advocate that interventions should be modified. It is important to modify interventions to take into account cohort beliefs, age-related changes in learning and information processing, sensory changes and health status. Knight (1999) describes how potential adaptations when working with older people are a result of cohort effects, context effects and specific challenges that are common in
later life, as opposed to being a consequence of being old developmentally. Knight suggests that adapting to work with older people is very similar to adapting to work with people of a different gender, culture, or ethnicity. The therapist needs to be aware of the differences which are inevitable when working with an individual from a different cohort.

Dick, Gallagher-Thompson and Thompson (1996) suggest some modifications of CBT for older people. Including those already discussed above, they draw attention to the relationship factors specifically the potential transference and countertransference that may occur. Laidlaw (2001) points out that one should not assume that adaptations will necessarily be needed and there is currently no empirical evidence to suggest that CBT needs to be adapted for older people who do not have cognitive impairments and are not frail. Laidlaw also highlights that the focus on the need to adapt CBT for use with older people has meant that the large body of evidence demonstrating the effectiveness of CBT in the adult population has been disregarded. Hinrichsen (1997) summarises some of the adaptations that have been suggested for IPT with older people, but also indicates that very few adaptations are required for IPT to be successfully applied with older people. The issues of whether approaches need to be adapted should be considered further by both researchers and clinicians.

**Psychotherapy in Primary Care**

There is a need for services providing psychotherapy to older people to consider how to make psychotherapy accessible to older people. Haley (1999) and Unutzer, Katon, Sullivan and Miranda (1999) have suggested that as most older people present through medical settings, psychologists need to adapt to provide psychotherapy within Primary care.

Arean et al. (2001) describe some preliminary findings from some research which has looked at integrating psychotherapy into medicine. Structured, brief therapies such as IPT and CBT may be particularly beneficial within primary care settings. In both of the studies described below, the psychotherapies were adapted for Primary care. In one study, CBT in addition to usual case management was a more effective way of
reducing depressive symptoms for older people than case management alone. These superior outcomes were maintained at a one-year follow-up and individuals were less likely to relapse. In the other study, individuals who showed a preference for psychotherapy over pharmacotherapy or who did not show improvement after 8-12 weeks of pharmacotherapy were offered IPT. They suggest that IPT was successfully integrated into medicine and can therefore be an effective and feasible method for treating depression in combination with pharmacotherapy. Further research is clearly needed into the effectiveness of offering psychotherapies such as IPT and CBT within Primary Care services.

CONCLUSIONS

The largest amount of research has been conducted into the effectiveness of CBT and IPT. Therefore, these approaches have the largest evidence base at present. This does not suggest superiority over other approaches but merely reflects which models are currently receiving the most attention by researchers. There seems to be evidence that CBT can effectively reduce depressive symptoms in healthy older people with no co-morbid illnesses. There is less research into which individuals will be best suited to CBT and whether CBT will effectively alleviate symptoms of depression for individuals with co-morbid conditions. Further research is needed into the long-term contribution of CBT and combined treatments. IPT seems to be effective in reducing symptoms of depression when combined with pharmacological treatments. There is also emerging evidence that IPT can effectively prevent relapses of depression when administered on a monthly basis with medication. Further research is needed into the individual contribution of IPT and it's effectiveness with older people with co-morbid conditions.

It is clear that research into the contribution of psychotherapies for alleviating the problems of depression in older people is considerably behind similar research for the 'younger' adult population. In particular, there is a lack of research into individual differences, gender, ethnicity and cultural differences. A great deal more research is needed into both CBT and IPT. In particular this research needs to attempt to identify
which psychotherapeutic approach would be best suited to which older people. Furthermore, research into the effectiveness of adaptations for research also needs to be conducted and consideration of how to implement psychotherapies in settings that older people generally present within. Another area that has been neglected within research to date is the effectiveness of combining different psychotherapeutic approaches (Niederehe, 1996).

In writing this essay the literature has alerted me to the large number of factors that need to be considered when deciding upon a therapeutic approach. Overall, I feel that whilst the research is limited, psychotherapies clearly can make a contribution to alleviating the problems of depression with older people.
REFERENCES


Department of Health (2001). *National Service Framework for Older People*


CLINICAL DOSSIER

This section of the portfolio contains a summary of the clinical dossier presented in Volume 2. This includes summaries of clinical experience gained over the six placements and summaries of five clinical case reports completed over the course of training.
OVERVIEW OF CLINICAL PLACEMENTS

This section of the portfolio provides a brief overview of the clinical experience gained on the six clinical placements completed during the three years of training. The full summary and logbooks of clinical experience, placement contracts and clinical evaluation forms are presented in Volume 2.
Overview of Clinical Placements

Adult Mental Health Placement

Setting: Community Mental Health Team

Dates: 15th October 2003 – 26th March 2004

Model: Primary - Cognitive behavioural therapy (CBT); Subsidiary – psychodynamic

Range of experience: Clinical work within the multi-disciplinary team consisted of outpatient work with individuals aged between 18 and 65, with a range of presenting problems including anxiety, depression, obsessive-compulsive disorder, panic attacks, eating disorders, and relapse prevention following recovery from psychosis. Assessments, formulations and interventions were guided by a cognitive-behavioural model and psychodynamic theories were considered during supervision. I completed two psychometric assessments to assess individuals’ cognitive abilities gaining experience with the Wechsler Adult Intelligence Scale (WAIS-III) and Wechsler Memory Scale (WMS-III). I also used multiple self-report measures to assess and measure outcomes. I also completed a service related research project (audit) which investigated internal communication procedures within four Community Mental Health Teams.

People with Learning Disabilities Placement

Setting: Community Team for People with Learning Disabilities

Dates: 7th April 2004 – 24th September 2004

Model: Systemic, CBT and psychodynamic models

Range of experience: Clinical work consisted of individual and joint work with a range of adults (aged 16-65) with mild to severe learning disabilities in outpatient and community (e.g. residential homes, day centres) settings. There was contact with individuals with autistic spectrum disorders and Down’s syndrome. Presenting problems included eating disorders, depression, coping with loss, managing transitions, challenging behaviour, aggression and coping with past sexual abuse. I co-facilitated a group for adults experiencing difficulties coping with emotions using CBT and problem solving approaches. Assessments included the WAIS-III, British Picture Vocabulary Scale, Leiter-R, Family Relations Test, WMS-III, and Neale Analysis of Reading ability. I also gained experience in completing systemic consultation meetings and co-facilitated a teaching afternoon about Down’s syndrome and dementia.
**Child and Family Placement**

**Setting:** Child and Adolescent Mental Health Service  
**Dates:** 13\(^{th}\) October 2004 – 24\(^{th}\) March 2005  
**Model:** Primary – Solution focused brief therapy; Subsidiary – CBT, systemic  
**Range of experience:** This placement provided the opportunity to work with a range of young people, from infancy through to adolescence, and their families. Presenting problems included anxiety, obsessive-compulsive disorder, aggressive behaviour, low self-esteem, feeding difficulties, enuresis, school phobia, coping with bereavement, and attention deficit hyperactivity disorder. I further developed my assessment skills using a range of self-report measures and I completed three cognitive assessments gaining experience in the administration and interpretation of the Wechsler Intelligence Scale for Children, the Wechsler Objective Reading Dimensions, and the Wechsler Preschool and Primary Scale of Intelligence. I also co-facilitated a behaviour management group based on the Webster-Stratton programme for parents with children with difficult behaviour. I observed and participated in both the family therapy and solution-focused therapy clinics gaining experience of these models.

**Specialist Child and Family Psychotherapy Placement**

**Setting:** Child and Adolescent Mental Health Service  
**Dates:** 20\(^{th}\) April 2005 – 23\(^{rd}\) September 2005  
**Model:** Brief psychodynamic therapy, solution focused therapy, and systemic therapy.  
**Range of experience:** This specialist placement focused on continuing to develop psychotherapy skills with young people and families. I was a member of a family therapy team and gained experience of structural and narrative family therapy models. This placement also provided opportunities to apply psychodynamic theories to individual work with young people. Presenting problems included, trichotillomania, eating disorders, depression, self-harm, attachment difficulties, behaviour problems, autistic spectrum disorder, anxiety and history of past sexual abuse. I gained experience working with young people with complex health issues or terminal illnesses (e.g. spina bifida hydrocephalus and acute lymphoblastic leukaemia). I also worked with the parents of children who were receiving input from other team members. I attended regular psycho-social ward rounds to discuss young people who were known to the service and also receiving medical care.
Older People Placement

Setting: Community Mental Health Team for Older People

Dates: 12th October 2005 – 29th September 2006 (split placement with Specialist 2)

Model: Psychoanalytical models, lifespan/life review and cognitive models.

Range of experience: Assessment, formulation and interventions have been conducted with older adults over 65 with a range of presenting problems including depression, anxiety, post-traumatic stress disorder, phobias, cognitive change with age, anger, history of sexual abuse, dementia, chronic pain, bi-polar disorder, psychosis and paranoia. This has included experience of the Single Assessment Procedure, and neuropsychological assessment using the WAIS-III, Trail Making Task, WMS-III, Wechsler Test of Adult Reading, and the Addenbrooke’s Cognitive Assessment (dementia screening tool). This placement has provided opportunities to apply psychoanalytic theories, particular Jungian, in therapeutic work with clients. I completed a psychoanalytic observation followed by discussion of the process account in a small group drawing on different psychoanalytic ideas. I gave a presentation and facilitated a discussion about the clinical use of a dementia screening tool within Community Mental Health Teams.

Specialist Adult Mental Health Systemic Therapies Placement

Setting: Specialist Psychological Therapies Service


Model: Systemic therapies (Primary - narrative therapy; Subsidiary – solution focused)

Range of experience: The aim of this specialist placement was to gain experience in the application of systemic therapies. I have worked with adults, and where appropriate their families, with complex psychological difficulties and severe and enduring mental health difficulties. This has included experience of using narrative therapy, solution focused therapy and family therapy models with people with agoraphobia, eating disorders, a diagnosis of borderline personality disorder, obsessive-compulsive disorder, self-harm, recently disclosed history of sexual abuse, post-traumatic stress disorder, anxiety and depression. I have been part of a systemic consultation service providing one-off consultations with clients, professionals and others in their support network. I co-facilitated a workshop for staff entitled “Dealing with Difficult Information” and co-facilitated an Away Day for an Assertive Outreach Team.
SUMMARY OF CLINICAL CASE REPORTS

This section of the portfolio contains summaries of the five case reports completed on clinical placement. The full versions are presented in Volume 2.
Adult Mental Health Case Report Summary

Cognitive-behavioural therapy with a 38 year old man presenting with severe depression

Referral

Steve (aged 38) was referred to the Clinical Psychologist of the Community Mental Health Team, by his Psychiatrist for assessment and treatment of long-standing depressive episodes.

Presenting Problem

Steve described low mood, a lack of willpower, low confidence, difficulties sleeping, reoccurring nightmares and irritability towards himself and others. He indicated that this had been present since leaving university in 2000. He held an extremely negative view of himself and the future. My initial impression was that Steve’s low mood was a result of negative beliefs he held about having no meaningful purpose in life.

Initial Assessment

The assessment consisted of unstructured face-to-face clinical interviews with Steve which occurred over 2 sessions. I also liaised with Steve’s Community Psychiatric Nurse and gathered additional information from case notes held at the CMHT. The Beck Depression Inventory II and a Daily Record of Activities Chart were completed after the initial assessment.

Formulation

Steve’s difficulties were considered in terms of Beck’s (1976) cognitive model of depression. Steve’s early experiences of disjointed schooling, difficulty “fitting in” at school, underachievement, and unfavourable comparisons between himself and his brothers, may have resulted in the development of the dysfunctional assumption that he is not as successful as others and therefore a worthless person. The unsuccessful applications to postgraduate courses may have activated the assumption that he is a worthless person. The activation of this dysfunctional assumptions resulted in the increased occurrence of negative automatic thoughts (NATs) such as “I’m a failure”. These thoughts in turn led to the reported symptoms of depression including: withdrawal from social activities; self-critical thoughts, suicidal thoughts and thoughts
of hopelessness; and feelings of shame, embarrassment and sadness; difficulties sleeping. These in turn further increased the occurrence of NATs, thus maintaining a vicious cycle. His belief that he is unsuccessful and worthless, has resulted in reduced activity levels, reluctance to start new things, and importantly avoidance of planning for the future due to expectations that he will fail. This therefore prevents opportunities to test out these beliefs.

**Intervention**

Steve attended 6 sessions rather than the 8 sessions planned. The intervention phase ended prematurely in the 5th therapy session, as Steve cancelled the following 2 sessions but returned for a final session, hence the planned therapeutic intervention was not completed. The intervention involved initially identifying Steve’s goals for therapy and socialising him to the CB model. I provided Steve with information about CBT and depression which were discussed in the sessions. The intervention mainly involved the application of cognitive techniques for identifying and challenging NATs. Whilst Steve was able to identify NATs he found it hard to challenge these thoughts especially when generating evidence against them. He found it difficult to complete homework tasks and this appeared to activate the dysfunctional assumption that he is worthless. Steve found the process of engaging with his thoughts very overwhelming and found it difficult to manage these emotions. This was played out within the therapeutic relationship as Steve attempted to seek the comfort that he desired from me. His request for comfort could be understood as a transference relationship as Steve may have recreated a situation in which an expression of emotions resulted in rejection. Following this Steve highlighted that he had felt too embarrassed to return for the following, intervening therapy sessions. He did however return for a final session after telephone contact had been made. We discussed the previous session and how the work was incomplete and the possibility for psychological work in the future.

**Outcome**

Steve thought the therapeutic work had been “beneficial”. In terms of reported symptoms of depression, the BDI-II score was reduced by 4 points, which is an indication of only a slight reduction in depressive symptoms. He stated that learning
about how his thoughts affect his emotions had been useful and expressed interest in working within a cognitive framework in the future. Whilst it was my impression that the intervention appeared to have a limited impact, the process of therapy seemed to have enabled Steve to begin to consider the beliefs and assumptions that he has and how these influence his mood and relationships with others. The intervention revealed that his level of motivation to change and his commitment to the approach were presently low. Furthermore, Steve indicated that whilst he could "rationally" understand the cognitive approach, he did not feel that this would be sufficient to change his mood or beliefs.

Re-formulation
Additional information emerged throughout the intervention that resulted in slight amendment of and addition to the original dysfunctional assumptions. In particular, Steve appeared to hold a strong core belief that he is a failure, and that he needs to succeed at everything he does in life. In the final session Steve referred to a set of "rules" that he tries to live his life by, and described setting himself extremely high standards. He acknowledged that these rules are often unrealistic and unhelpful for him. The long-standing nature of his depression and reported interpersonal difficulties (also observed in the therapeutic relationship) suggested that schema focused cognitive therapy may be more appropriate due to the emphasis on the deepest level of cognitions, which Young defines as Early Maladaptive Schemas (EMS).

Critical Evaluation
Although Steve began to gain greater understanding of and access to his thoughts and emotions, the intervention did not result in a significant reduction of his depressive symptoms. In hindsight considering the severity of Steve's depression and low motivation a longer-term intervention may have been more beneficial. However, the short-term intervention allowed exploration of whether the approach was appropriate for Steve and also upon re-formulation the possibility of future schema-focused cognitive therapy. Completing this therapy provided opportunities to consider the limitations of some CBT strategies. In particular, the use of a record form that encouraged Steve to comment on the evidence for his NAT was not appropriate for him.
People with Learning Disabilities Case Report Summary

A cognitive-behavioural problem-solving group entitled “Feeling Better Together” for four individuals with learning disabilities experiencing difficulties coping with their emotions

Referral of the Problem

Six individuals (3 women, 3 men) were identified to participate in a group for people who were experiencing difficulties coping with their emotions. Four individuals were assessed to be suitable and expressed an interest in joining the group.

Presenting Problem

Presenting problems included difficulties managing feelings of anger, difficulty coping with anxious feelings in social situations and difficulty coping with feeling low.

Initial Assessment

The majority of information came from the face-to-face initial assessment interviews conducted individually with each person who opted into the group. Individuals’ case notes were also examined. Criteria were used to determine whether individuals would be suitable for the group including: their ability to identify difficulties and set goals; motivation to change and work on difficulties; availability of support in daily life to be able to tolerate the time-limited group processes; sufficient verbal expressive communication to be able to participate in discussions and contribute to group; discrete rather than complex multiple difficulties. Due to the diversity of the group members and unavailability of other outcome measures, subjective rating scales in relation to the individuals chosen goal were selected as appropriate measures for evaluation of progress.

Formulation

People with learning disabilities may have problems with emotional awareness and difficulties understanding their emotions and therefore may be more vulnerable to experiencing stresses in life due to difficulties with interpersonal and independence skills. This may then place them at an increased risk to develop depression, anxiety, low self-esteem, and other emotional difficulties. The four individuals selected for the
group all presented with difficulties dealing with emotions and all reported to have limited strategies for dealing with emotions or difficulties in their lives. Individual formulations were presented for each group member. It was hypothesised that problems were being maintained by difficulties expressing emotions, limited understanding of the link between thoughts, feelings and behaviour, and limited strategies for dealing with difficult feelings. Low self-esteem and confidence were also thought to be contributing to and maintaining their difficulties.

**Intervention**

A closed time-limited group intervention for 12 weeks using a cognitive behavioural framework and problem-solving approaches was conducted. The initial sessions focused on 'getting to know each other'. Discussion of individual goals occurred in these initial sessions, which enabled group members to find out more about each other and their difficulties. The main areas covered during the intervention were decided amongst the group members and included being assertive, managing anger, feeling low, anxious feelings/phobias and coping with loud noises. A problem-solving approach was used to look at different emotions and how to cope with these feelings. The cognitive-behavioural model was also used to highlight the link between thoughts, feelings and behaviour and to highlight that coping strategies could focus on different levels, including the physiological aspects (e.g. deep breathing) cognitions (e.g. challenging distorted thinking styles) and behaviour (e.g. attempting previously avoided situations). Repetition of the model appeared to be effective and group members began to offer more suggestions and alternatives as the sessions progressed. In the final sessions we focused on issues that were common to all group members, low self-esteem and confidence. In terms of group processes (Yalom, 1995), group members experienced a sense of ‘universality’ and found it reassuring to find out that others struggle with their emotions too. The group became more cohesive as group members were able to self-disclose, talk about very difficult situations, and respond to each other’s difficulties.

**Outcome**

Three weeks after the final session, all group members attended a follow-up post assessment interview. Three group members reported a reduction in the severity of
their problem, and three reported a reduction in the frequency. The self-esteem data was only available for one individual and showed improved overall self-esteem. Three of the group members had particularly benefited from the group and appeared to be able to generalise these skills to new problems and situations, as evidenced in the final sessions. The other group member had developed a new strategy for coping with difficult situations, but was less able to generalise the skills to new situations. She also appeared to find it harder to understand the link between her thoughts and her feelings possibly due to her more moderate level of learning disability. Two individuals seemed to become more confident during the group. All individuals reported that others in their life had noticed a difference in them because of the group. All individuals evaluated the group positively (e.g. "interesting", "helpful", "useful").

Reformulation
The individual formulations appeared to remain valid as individuals benefited from the problem-solving approach which resulted in an increased ability to cope with their emotions. In hindsight one individual benefited the least from the intervention as a result of her more moderate learning disability and an individual approach with more involvement from her carers may have been more effective for her.

Critical Evaluation
Overall, the group intervention appeared to be beneficial for each individual. One of the main limitations of the work was the lack of objective measures to evaluate change. It might have also been beneficial to have utilised the 'here and now' experience of the group and 'interpersonal learning' more explicitly in the group so that individuals were able to reflect on their interactions and behaviour (Yalom, 1995). Although there were examples of when the group appeared to be quite cohesive (e.g. self-disclosure), overall I feel that the group members remained focused upon their own goals and this may be a result of the small size of the group.
Child and Family Case Report Summary

Bereavement work with an 8 year old boy and his family based on developmental and family systems theories

Referral

Mark (aged 8) was referred to the Child and Family Service for Mental Health by his GP, as he was extremely distressed at any mention of death, which appeared to be linked to the death of his paternal grandfather three years ago.

Presenting Problem

The main concern for both Mark and his family was the amount of distress that Mark continued to experience following his grandfather’s death. Mark would become upset upon any mention of death or related issues, occurring at least three times a week, disrupting him both at home and school. Mark’s mother was concerned that Mark’s difficulties were a sign that he may be vulnerable to developing depression, as there is a family history of depression in the paternal side of the family.

Assessment

The information came from face-to-face clinical interviews with Mark and his family, which occurred over 2 sessions. The circumstances of the grandfather’s death, which occurred when Mark was 5½, were explored. Mark and his sister experienced the grandfather’s death as unexpected. Mark’s parents decided that he should not attend the funeral or the separate ceremony held to spread his ashes. The assessment revealed that Mark had continued to be distressed since the grandfather’s death, talking a lot about death and dying and becoming anxious and clingy when separated from his mother. The family acknowledged that they try to protect Mark from any death related cues and avoid talking about these issues as he becomes very distressed.

Formulation

Mark’s difficulties were understood in developmental terms, and by drawing on models of the normal stages of grief and family dynamics. It was hypothesised that his difficulties may suggest that he has become ‘stuck’ within this process of grieving and had not therefore been able to progress to the final grief process of acceptance.
a developmental perspective, children’s understanding of death varies according to
their age and cognitive development. It was hypothesised that at the time of the death
Mark did not understand the finality of death and that as he has grown older he has
needed to assimilate this death within this new knowledge (Carr, 1999). This might
have prolonged the grief process for him, and he may have remained oscillating
between different grief processes as his understanding of death has developed. In
conjunction to this, Mark was unclear about many of the details of his grandfather’s
death and there was no opportunity for Mark to partake in the funeral and say
goodbye. Furthermore, the initial assessment also highlighted that conversations
within the family about illness, death and the grandfather were most often avoided.
Thus, Mark’s developing understanding of the concept of death in conjunction with
the family response of avoiding these issues may have hindered his progression
through the grief process. Finally, it was also hypothesised that Mark’s grief was
influenced by his father’s grief and that he may avoid talking about his grandfather’s
death so as not to upset his father.

**Intervention**

The intervention was guided by the family-based grief work described in Carr (1999).
Mark and his mother attended all 8 sessions, but his father and Chloe attended only
four and three sessions respectively. The intervention initially began with the family
talking about the grandfather and was facilitated through the creation of a ‘memory
box’. Discussions about the feelings that individuals’ experienced provided Mark with
an opportunity to hear how others reacted to this loss, in particular his father and
sister. Repetition of these areas through completion of activity sheets was important
and provided Mark with time to process the information and ask more questions.
Mark and Chloe each created a “Feelings Volcano”, which facilitated discussions of
the feelings that they experienced when their grandfather died. The final sessions
focused on how the family will continue to talk about these difficult issues and
remember the grandfather in the future. Time was also spent talking about different
reactions to loss and the impact of Mark’s developmental age at the time of the death.
I also employed narrative techniques to explore alternative stories of Mark’s ability to
cope with stress which served to challenge his mother’s belief that he would
experience depression like his father.
Outcome
I asked Mark at each session to rate things on a scale of 1-10 (where 10 was the best things could be and 1 the worst). His self reported ratings went from 1-2 in the first appointment to 10 in the final appointment. This indicates that Mark felt that his situation had improved and that he was coping significantly better. When asked to rate his confidence that he will remain at 10, Mark stated that he was 80% confident. The family reported a number of subjective changes, including no longer avoiding discussions about death or avoiding death related cues. He was able to talk about both his grandfather and death without becoming upset and they had noticed that he had not cried outside of the sessions since early in the intervention. Following the final session, Mark’s mother reported that he coped extremely well with an unexpected death in the extended family.

Reformulation of problem
The majority of new information that emerged during the intervention supported the original formulation. The intervention revealed the importance of the family system acknowledging a shared loss and the impact this has on all family members. The opportunity to talk about issues that had previously been avoided was important and valued by the family. Mark’s difficulties coping with the loss of his grandfather bought the family together at a time when they were not spending any time as a family. It could therefore be hypothesised that on some level Mark’s difficulties served an additional function of uniting the family.

Critical Evaluation
Overall, I feel that the intervention successfully achieved the goals established during the assessment. In my opinion the most important aspect of the intervention was enabling the family to have space and time to talk about the loss and the impact this had on each of them as well as the whole family. A large part of my role was to facilitate the family to think and talk about the loss together. Challenges included managing the absence of Marks’ father in sessions and ensuring that Mark was included through integrating creative activities to facilitate discussions.
Specialist Child and Family Case Report Summary

Psychotherapy with a 17-year-old adolescent female with depressive symptoms and self-harm behaviour drawing on psychodynamic and developmental models

Referral
Jenni (aged 17), was referred to the Child and Family Service for Mental Health by her GP. She had been experiencing low mood over the past two years which was associated with self-harm behaviour including lacerating her forearms and thighs.

Presenting Problem
Jenni reported changes in her mood for no apparent reason, but stated that she felt low or sad most of the time. She found the fluctuation of her emotions draining and self-harmed as a way of getting her feelings out. She had recently found this less effective and was concerned that she might resort to more severe means of harming herself to manage her feelings. When Jenni experienced periods of low mood and self-harmed she became irritable and withdrew from the family unit. She wanted to talk about events in her past that she thought were linked with her low mood, and difficulties she experiences in friendships and sexual relationships.

Initial Assessment
The majority of the information gathered during the assessment came from an initial meeting with Jenni and her mother. A second assessment session was conducted with the whole family upon Jenni’s request. The initial assessment explored the history and development of her difficulties. Jenni completed a background information sheet prior to attending the first session and the Beck Depression Inventory. She obtained a score which placed her within the moderate to severe range. She had a pessimistic outlook for the future and suicidal thoughts, but no suicidal intention or plans to commit suicide.

Formulation
Jenni’s difficulties were considered within psychodynamic terms whilst also considering theories about adolescence and identity development. Jenni described past experiences of perceived rejection from her peers and family, and a difficult
childhood as a result of disabling health problems. She described a lack of space to reflect on these events and I hypothesised that Jenni may have conflicting emotions which were difficult to explore and tolerate. I wondered if some of Jenni’s current difficulties were precipitated by her developmental stage, as adolescence is a time of identity and role development. I wondered if Jenni had a fear of confronting her emotions and exploring her feelings following the events of her past. The defence mechanism ‘acting out’ is a neurotic defence whereby disturbing feelings are discharged into an action so as to avoid thinking about them (Lemma, 2003). Therefore, it was hypothesised that Jenni had discharged disturbing or conflicting feelings into self-harm behaviour to avoid thinking about them. She also described difficulties forming relationships as she feared rejection by others and placed their needs before her own. It was hypothesised that Jenni managed her anxiety and fear of being rejected by initially attempting to please others to her own detriment and also by terminating relationships before she becomes emotionally attached.

**Intervention**

I conducted the intervention independently for only five sessions. The planned therapeutic intervention was not completed due to missed sessions. Jenni cancelled three appointments and did not attend two as she started full-time employment and did not feel able to ask for the time away to attend. The sessions therefore mainly focused on developing a therapeutic setting whereby tentative interpretations about patterns and emerging themes were identified. Each session lasted 50 minutes and was conducted in the same room to help create a consistent therapeutic setting. The main psychodynamic techniques included listening to the unconscious communication and making interpretations through these discussions. It felt like Jenni was ‘purging’ herself of all the emotions that she could not tolerate and as the sessions continued I became aware of her use of projection. A number of themes emerged during the intervention including: a difficulty with boundaries which appeared to reflect her capacity to tolerate intimacy; non-attendance which could be understood as an effect of transference and Jenni’s resistance of forming a relationship at a time when she was striving for independence; being used and abused by others; and identity development.
Outcome
Jenni completed the Beck Depression Inventory prior to the assessment session and in the final session. Her score reduced from being in the moderate to severe range, to being in the minimal range indicating a reduction in the symptoms of depression. The reduction was also consistent with Jenni’s reports in the final session that she was feeling considerably happier and less irritable. She reported that she was getting on better with her family and negotiating with her parents. She stated that she no longer felt that she should place her own needs last in order to keep friendships and felt more comfortable with her own identity, no longer feeling that she should change herself to fit in with others.

Reformulation
Overall I thought that the ideas presented in the formulation were supported during the intervention. Specifically, Jenni’s behaviour within the therapeutic relationship seemed to highlight her ambivalent feelings towards intimacy. The intervention also revealed more information about Jenni’s relationship with her parents which could have been explored further if the sessions had continued. During the intervention I became aware that Jenni often used the defence mechanism of projection to manage intolerable emotions. I wondered if Jenni’s fear that others would reject her was in fact a projection of her own fear that she would not be able to maintain relationships with others and would in fact reject them.

Critical Evaluation
Whilst the planned intervention was not completed, Jenni appeared to benefit from the brief number of sessions that she attended. She appeared to find it helpful to have some space to think about emotions and experiences that she tended to consciously or unconsciously avoid. If I were to embark on another piece of psychodynamic work with a similar adolescent client I would consider open-ended consultations as adolescence is a time when independence and self-sufficiency are important.
**Older People Case Report Summary**

A psychometric assessment of a 76 year old woman presenting with short-term memory problems

**Referral**

Sue (aged 76) was referred by her doctor to the Community Mental Health Team for Older People (CMHTOP) for assessment in terms of long-standing short-term memory problems. Following outpatient assessment with the Psychiatrist, Sue was referred for psychometric assessment of her cognitive abilities to explore whether her presenting difficulties were a result of an underlying organic pathology.

**Presenting Problem**

Sue was experiencing difficulties with her short term memory. Her daughters and son commented that she had become increasingly forgetful and uncharacteristically aggressive. They had concerns for her safety, living alone in a large house and had noticed that she was losing interest in her appearance, at times looking unkempt. Sue reported that she had noticed difficulties with her memory for about one year. Her daughter reported that they first noticed her deteriorating memory four years ago, and that this had recently accelerated dramatically.

**Background Information**

Sue was a high achieving student and stayed in education until she was 16. She reported that she completed her exams and did well. She trained and worked as a medical secretary, and left full time employment when she became pregnant with the first of four children. Her last employment was part time as a medical secretary. She lives alone in the family home following her partners death 20 years ago. Sue had a history of high blood pressure. The Psychiatrist hypothesised that she may have vascular dementia and requested that a Computed Tomography (CT) Scan and blood tests be completed, the results of which were normal. There was also concern that Sue may have experienced a series of small strokes that had not been detected. The Mini Mental State Examination had been administered at outpatient appointments, and she scored above the cut-off for dementia on each occasion. The Psychiatrist also administered the Geriatric Depression Scale and her responses were not indicative of depression. No brain atrophy or abnormality were detected via the CT scan.
Hypotheses
1. Sue's cognitive profile would indicate age-appropriate cognitive decline.
2. Sue's cognitive profile would be indicative of cognitive decline above that expected as a result of natural aging and would be suggestive of a dementia, i.e. memory impairment and one or more of either aphasia, apraxia, agnosia or a disturbance in executive functioning.

Assessment
The following tests were administered: the Wechsler Adult Intelligence Scale to gather information about Sue's current level of functioning across a range of abilities; the Wechsler Test of Adult Reading to provide an estimate of Sue's pre-morbid functioning; the Addenbrooke's Cognitive Examination Revised which detects milder forms of dementia and measures attention, orientation, verbal fluency, language, visuospatial abilities, and episodic and semantic memory; a selection of subtests from the Wechsler Memory Scale (Third Edition) to assess memory impairment; and the Trail Making Task forms A and B to assess executive functioning.

Findings
Sue's pre-morbid functioning as assessed by the WTAR placed her within the high average range. There was a significant and abnormal discrepancy between her Verbal IQ, which was within the average range, and her Performance IQ, which was in the low-average to average range. Her overall score on the ACE-R was below the lower cut-off of 82 and thus indicative of a dementia. In terms of memory impairment, on the ACE-R she obtained a score of 16/26 on the memory domain, and she performed within the low average to borderline range on all of the WMS-III subtests measuring verbal and visual immediate and delayed recall (scaled scores 1 - 6). In relation to executive functioning, Sue scored within the low-average to average range on tasks that measured ability to solve novel problems. She scored within the average range on tests of attention, but showed some decline in verbal fluency as assessed by the ACE-R.

Discussion
The assessment revealed that there had been some decline in cognitive functioning. Her memory difficulties were significantly impaired beyond that expected due to
normal aging. Sue showed a marked and significant impairment in learning new information and remembering this. Whilst she was able to retain small pieces of information for long enough to repeat them or manipulate them, she could not store or retrieve this information. Sue's recognition score for auditory information was very low, suggesting that information is not encoded. The hippocampus, located on the inside of each temporal lobe is important in learning new information and retention. The assessment suggests that there may be some deterioration in this part of Sue's brain. Further brain scans were needed to explore this. Sue scored below the second cut-off score on the ACE-R which is highly indicative of dementia. There was some evidence of cognitive decline from pre-morbid estimates. Sue also showed some impairment in verbal fluency, a measure which is thought to be associated with executive functioning. Sue's memory was significantly impaired and the assessment highlighted that other cognitive abilities may also be deteriorating. On the basis of her ACE-R score indicating memory impairment, a reduction in verbal fluency score and general cognitive decline as assessed through the WAIS-III and WTAR, Sue's presentation appeared to fit the criteria for dementia.

**Recommendations**
The findings were fed back to Sue, her family and the team. I recommended that further monitoring and re-assessment be conducted through administration of alternative forms of the ACE-R which would detect further deterioration in other areas of cognitive functioning. I referred Sue to a Social Worker within the team for further assessment of her current needs in terms of support for daily living. Further assessment could also help determine the underlying cause of Sue's dementia.

**Critical Evaluation**
The assessment clarified Sue's significant memory difficulties and identified that an underlying pathology of dementia existed. I think further tests could have been conducted to provide more information about Sue's current difficulties, and the underlying cause of this. Whilst I focused on Sue's memory impairments, the assessment could have benefited from further exploration of complex abilities such as executive functioning, however this was not possible as Sue did not want to proceed with further testing at this time.
RESEARCH DOSSIER

This section of the portfolio presents the research work conducted over the three years of the course. It contains the service-related research project completed during the first year, the major research project completed in the third year and a research checklist which details the research skills gained during the course.
Service Related Research Project

An audit of an NHS Trust’s Communication Policy: An investigation of internal communication procedures in four Community Mental Health Teams (CMHTs)

Year 1: June 2004
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ABSTRACT

Introduction
Good communication within the NHS has been highlighted as essential (Department of Health, 2002). NHS Trusts’ have developed Communication Policies which provide recommendations to ensure that internal communication is effective. Comparing practice with existing standards forms part of the clinical audit cycle, (Crombie, Davies, Abraham, & Florey, 1993).

Objective
The aim of this study was to examine whether the recommendations from the Trust’s Communication Policy and The Report of the NHS Taskforce on Staff Involvement (Department of Health, 1999) were being met in practice within four Community Mental Health Teams (CMHTs) of a large Learning Disability and Mental Health Trust.

Method
A questionnaire was designed from the recommendations outlined in these documents and informal discussions with staff within one of the CMHTs. This was administered to 60 staff, of which 30 responded.

Results
The results showed that the Trust was not meeting all of the recommendations measured. Specifically, the staff were not receiving the Team Brief on a monthly basis, face-to-face by a Line Manager or at Team Meetings, and were generally not receiving the Trust Newsletter. Participants felt that the communication process was at best only sometimes a two-way process, clear and understandable, regular, open, and accessible, and were generally dis-satisfied with internal communication.

Discussion
The limitations of the study were discussed and the some possible explanations for the results were explored. Finally, suggestions for how the results can inform service delivery and the need for the study to be repeated were discussed.
ACKNOWLEDGEMENTS

Firstly, I am grateful to the staff at the Community Mental Health Team (CMHT) who provided me with ideas about useful areas to investigate and supported the distribution of the questionnaire. Specifically, I would like to thank my University Supervisor for her continued support in designing and revising the questionnaire and examining the data once completed. I would also like to thank my Field Supervisor and the Assistant Psychologist for their comments on drafts and completion of the pilot study. Finally, I would like to thank the participants for taking the time to complete the questionnaire.
INTRODUCTION

Good communications has been highlighted as essential "to the success of any large organisation in the modern world" (pp.4; Department of Health, 2002). Communication between the managers in the NHS and clinicians is especially important whilst the NHS is undergoing changes to modernise services. The Improvement Leaders' Guide to Managing the Human Dimensions of Change: Working with Individuals (NHS Modernisation Agency, 2002), states that a breakdown in communication can often result in conflict within organisations.

An NHS Taskforce was established in 1998 to look at issues of staff involvement. This taskforce produced a report which identified good communication as essential for staff involvement. The Report of the NHS Taskforce on Staff Involvement (Department of Health, 1999) identified that communication should be a two-way process which is transparent, regular, consistent, open, clear and accessible. It also stated that information should be communicated through a variety of mediums.

NHS Trusts have developed Communication Policies which provide guidelines to ensure that both internal and external communication is effective. Comparing practice with existing standards forms part of the clinical audit cycle. The audit cycle is a continuous process in which standards are set, practice is observed and then compared to the standards, changes are made and the cycle continues (Crombie, Davies, Abraham, & Florey, 1993).

This study was an attempt to audit part of the Communication Policy of a large Mental Health and Learning Disability Trust in the South of England. Current practice within the Trust in four CMHTs was compared against the recommendations of the Trust’s Communication Policy and the Report of the NHS Taskforce on Staff Involvement (Department of Health, 1999). The Trust was in the process of implementing a major re-organisation of services. Informal discussions with staff within one of the CMHTs highlighted that individuals were keen for a study to be conducted into the process of service changes, in particular the communication of information. Due to the socio-political context of these changes it was felt that an evaluation of the change process
and communication specific to re-organisation might be seen as threatening to the Trust. Barker, Pistrang and Elliott (2002) highlight that when conducting evaluative research it is important to take action to reduce this sense of threat. It was therefore decided that a study focusing on internal communication in general might be perceived as less threatening but could still be helpful to the Trust.

The research was important for the services, and the wider Trust, as effective communication has been highlighted as important in improving and maintaining staff morale (Department of Health, 2003), and in implementing change (Department of Health, 2002). The Report of the NHS Taskforce on Staff Involvement (Department of Health, 1999) suggested that NHS organisations should "review (and, if necessary, change) the way they communicate to ensure that it is effective" (pp. 43).

The Trust’s Communication Policy (Appendix 1) set out guidelines for internal communications within the Trust. The policy recommended that:

1. Staff should have regular Team Meetings

2. A monthly update from the various Directorates called “Team Brief” should be communicated at these meetings to ensure staff have a wider understanding of the organisation’s plans and objectives.

3. Team Brief should be based on five principles:
   - Issued on a monthly basis
   - Presented face-to-face by line manager
   - At Team Meetings
   - About relevant issues
   - Provides an opportunity for feedback

4. Information for the Team Brief should be guided by the five “P”s:
   - Plans
   - Policy
   - People
   - Praise
   - Points for Action
5. A Trust Newsletter will be produced for staff, and staff are encouraged to contact the Communications Team to include any news from their area.

Objectives

This study aimed to examine the internal communication process within the Trust. A questionnaire was developed as an established measure did not exist. The questionnaire was designed to investigate staff perceptions of internal communication and the degree to which the recommendations from the Trust’s Communication Policy and The Report of the NHS Taskforce of Staff Involvement (Department of Health, 1999) were being met in practice. Questions were also included to elicit satisfaction levels.
METHOD

Participants

The questionnaire was given to all the staff working in four CMHTs. Of these 60 staff, 30 people completed it, a response rate of 50%. To maintain anonymity, participants were not asked their age, sex or the team they worked for. Individuals’ profession, grade and length of time working in the Trust was requested, although many responders did not provide this information. The data obtained suggested that participants were from nursing, psychiatry, psychology, social work, occupational therapy and administration. The mean length of time working in the CMHT was approximately 6 years (N = 24; range = 1 month – 15 years). The mean length of time working within the NHS Trust was 12 ½ years (N = 23; range = 1 month – 36 years).

Design

This study was a non-experimental descriptive design, (Barker, Pistrang and Elliott, 2002). The questionnaire entitled “Are we communicating effectively?” was designed independently. Drafts of the questionnaire were discussed with both the Field and University Supervisors and amended accordingly.

Materials

Development of questionnaire

The main content of the questionnaire was determined by the recommendations made in the Trust’s Communication Policy, The Report of the NHS Taskforce on Staff Involvement (Department of Health, 1999) and informal discussion with staff from one of the CMHTs. Staff were keen for the questionnaire to contain questions about satisfaction with the communication of a variety of different information. Consequently, the questionnaire covered the following topics:

1. Methods of communication e.g. face-to-face, e-mail
2. Preferred method of communication
3. Regularity of Team Meetings and accessibility to information.
4. The five principles of Team Brief
5. The content of Team Brief
6. Trust Newsletters
7. General Communication Process
8. Satisfaction with communication process and information communicated.

The final questionnaire was divided into 10 sections. It assessed each of the areas identified above and gathered information about the individual's awareness of the Communication Policy and demographic information. As recommended in Barker, Pistrang and Elliott (2002), the questionnaire started with neutral questions to help engage participants and a brief introductory sentence was included at the beginning of each section to inform the reader of its content. Information that might be considered irrelevant (e.g. demographics) was put at the end. A mixture of fixed-choice, 5-point likert scales and open-ended questions was included to encourage participation. All likert scales used in the questionnaire included a mid-point as this was felt to be less coercive and acknowledged that neutrality is a genuine judgement (Barker, Pistrang & Elliott, 2002). Detailed information about the selection of items included in each section can be found in Appendix 2 and the complete questionnaire in Appendix 3.

Pilot Study

A draft of the questionnaire was completed by the Field Supervisor and an Assistant Psychologist to check item wording, clarity, simplicity, structure, and also to give comments on the content of the questionnaire as a means of content validation. Some minor amendments to the questionnaire were made. Both individuals said that the questionnaire appeared to cover the appropriate areas identified from the literature and staff. They also said that the questionnaire was an appropriate length and could be completed in about 5-10 minutes. A Flesch Readability Analysis (Microsoft Word XP) was conducted, which found a Flesch-Kincaid Grade Level of 6.6 which is an equivalent reading age of an 11-12 year old.

Procedure

The research proposal and questionnaire was sent to the Team Leader managing the four CMHTs. Authorisation to complete the research was granted (Appendix 4). A
record of the research activity was also logged with the Clinical Audit Committee, (Appendix 5). A signed statement completed by the Field Supervisor confirmed that the research did not need ethical approval (Appendix 6). An information sheet was produced to provide information about the study, anonymity and confidentiality (Appendix 7). Telephone contact was made to the receptionist of each CMHT to agree a process for its distribution. The questionnaire, information sheet and return envelope were given to staff during a Team Meeting, and written instructions were provided to be read out by the chair (Appendix 8). Staff not present at the Team Meeting received the questionnaire with the minutes. Staff were reminded to complete the questionnaire during a Team Meeting after 2 weeks and then again the following week.
RESULTS

Thirty questionnaires were returned in total, 13 immediately and 17 after the reminders. Not all participants answered every question and 11 participants did not report their profession. From the information obtained (see Table 1) Nursing was the profession most highly represented in this sample. Due to the missing data it is difficult to know how representative the participants were of the whole sample however it is possible that certain professions may be under-represented. The number of participants who responded are indicated for each of the descriptive statistics reported. The findings from the main sections of the questionnaire are reported below. Information gained through additional comments sections is included in Appendix 9.

Table 1 Participants profession

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>Number of Participants (N = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>10</td>
</tr>
<tr>
<td>Social Work</td>
<td>2</td>
</tr>
<tr>
<td>Psychology</td>
<td>3</td>
</tr>
<tr>
<td>Administration and Clerical</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>1</td>
</tr>
</tbody>
</table>

Awareness of the Trust’s Communication Policy

Only 57% of participants were aware that the Trust had a Communication Policy and only 43% had read this policy. 87% were aware of where the Trust’s policies are kept, and therefore where to find it.

Methods of communication

The Trust used a variety of different methods to communicate with staff (Table 2). The methods of communication with the highest percentage of nearly always and
always used responses were; communication face-to-face in Team Meetings (60%); face-to-face from colleagues (57%) and via e-mail (57%).

Table 2 Methods of communication responses

<table>
<thead>
<tr>
<th>To what extent is information communicated:</th>
<th>Never (%)</th>
<th>Rarely (%)</th>
<th>Sometimes (%)</th>
<th>Nearly Always (%)</th>
<th>Always (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to face – individually with Line Manager (N = 29)</td>
<td>0</td>
<td>17</td>
<td>45</td>
<td>35</td>
<td>3</td>
</tr>
<tr>
<td>Face to face – with representative for Line Manager (N = 29)</td>
<td>4</td>
<td>24</td>
<td>55</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Face to face – from colleague (N = 30)</td>
<td>0</td>
<td>3</td>
<td>40</td>
<td>47</td>
<td>10</td>
</tr>
<tr>
<td>Face to face – in Cascade meeting, NOT Team Brief (N = 27)</td>
<td>22</td>
<td>33</td>
<td>26</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Face to face – at Team Meeting (N = 25)</td>
<td>0</td>
<td>4</td>
<td>36</td>
<td>48</td>
<td>12</td>
</tr>
<tr>
<td>By e-mail (N = 28)</td>
<td>7</td>
<td>7</td>
<td>29</td>
<td>43</td>
<td>14</td>
</tr>
<tr>
<td>Letter (N = 28)</td>
<td>0</td>
<td>53</td>
<td>43</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Phone call (N = 29)</td>
<td>24</td>
<td>38</td>
<td>24</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>On bulletin boards – Trust website (N = 29)</td>
<td>7</td>
<td>21</td>
<td>48</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>On bulletin boards – on wall in place of work (N = 29)</td>
<td>7</td>
<td>35</td>
<td>41</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Away days (N = 28)</td>
<td>32</td>
<td>39</td>
<td>18</td>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>
Preferred Method of Communication

Individuals were asked an open-ended question about their preferred method of communication and the responses were categorised (Appendix 9). Individuals appeared to value communication of information face-to-face via the Team Meeting or their line manager and in writing, (see Table 3). Only a small percentage of people preferred information to be communicated just through writing (15%).

Table 3 Preferred Method of Communication

<table>
<thead>
<tr>
<th>Method of Communication</th>
<th>Percentage of responses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N = 27)</td>
<td></td>
</tr>
<tr>
<td>In writing – e-mail or letter</td>
<td>15</td>
</tr>
<tr>
<td>Face-to-face at Team Meeting or via Line Manager</td>
<td>52</td>
</tr>
<tr>
<td>Both in writing – e-mail or letter and face-to-face at Team Meeting or via Line Manager</td>
<td>33</td>
</tr>
</tbody>
</table>

Team Meetings

All of the participants reported that Team Meetings were held weekly and 77% attended weekly, however 17% of participants were unable to attend or rarely attended, (Table 4).

Table 4 Attendance at Team Meetings

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage of response (N = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>77</td>
</tr>
<tr>
<td>Fortnightly</td>
<td>3</td>
</tr>
<tr>
<td>Monthly</td>
<td>3</td>
</tr>
<tr>
<td>Rarely</td>
<td>7</td>
</tr>
<tr>
<td>Never</td>
<td>10</td>
</tr>
</tbody>
</table>
Principles of Team Brief

Recommendation: Occurs on a monthly basis

Table 5 shows that the Team Brief is not always communicated on a monthly basis as only 40% of participants reported that this occurred nearly always or always.

Recommendation: Team Brief is communicated face to face by Line Manager

Table 5 indicates that 75% of the participants felt that the Team Brief was never or rarely communicated face-to-face by their Line Manager. Only 4% of participants felt that this occurred nearly always or always. This suggests that the Team Brief was generally not being communicated to staff face-to-face by their Line Manager.

Recommendation: Team Brief occurs at Team Meetings

Table 5 shows that a large percentage (71%) of the participants reported that the Team Brief was rarely or never communicated at Team Meetings. Only 22% of the participants felt that it was nearly always or always communicated at the Team Meeting. Furthermore, 8 of the additional comments on the Team Brief section stated that the Team Brief was communicated to staff via e-mail (see Appendix 9).

Recommendation: Team Brief contains information about relevant issues

The largest percentage of participants (46%) agreed that the Team Brief contained information about relevant issues, although 29% of participants disagreed or strongly disagreed and 25% held no strong opinion.

Recommendation: Team Brief is an opportunity for feedback - from Management

Only 28% of the participants felt that the Team Brief was nearly always or always an opportunity for feedback from Management (see Table 5).
Recommendation: Team Brief is an opportunity for feedback – to Management

Only 21% of participants agreed that Team Brief was *nearly always* or *always* an opportunity to feedback to Management, and 47% felt that this occurred *rarely* or *never* (See Table 5).

### Table 5 Communication of Team Brief responses

<table>
<thead>
<tr>
<th>Recommendation:</th>
<th>Never (%)</th>
<th>Rarely (%)</th>
<th>Sometimes (%)</th>
<th>Nearly Always (%)</th>
<th>Always (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occurs on a monthly basis (N = 25)</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>28</td>
<td>12</td>
</tr>
<tr>
<td>Team Brief is communicated face to face by Line Manager (N = 28)</td>
<td>54</td>
<td>21</td>
<td>21</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Team Brief occurs at Team Meetings (N = 28)</td>
<td>39</td>
<td>32</td>
<td>7</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Team Brief is an opportunity for feedback – from Management (N = 28)</td>
<td>18</td>
<td>21</td>
<td>32</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Team Brief is an opportunity for feedback – to Management (N = 28)</td>
<td>18</td>
<td>29</td>
<td>32</td>
<td>14</td>
<td>7</td>
</tr>
</tbody>
</table>

### Content of Team Brief

Table 6 displays participants’ agreement in relation to the content of the Team Brief as recommended in the Communication Policy. Between 28% - 46% of the participants held no strong opinion on whether the Team Brief contained this information. The area that the highest percentage of staff agreed the Team Brief contained information on was Trust Plans (46%). The results indicated that 43% *disagreed* or *strongly disagreed* that the Team Brief praised staff or services, and 39% of participants...
disagreed that the Team Brief conveyed information about services or people performing exceptionally in the Trust.

Table 6 Responses about the content of Team Brief

<table>
<thead>
<tr>
<th>Team Brief contains information about:</th>
<th>Strongly Disagree (%)</th>
<th>Disagree (%)</th>
<th>Neither Agree or disagree (%)</th>
<th>Agree (%)</th>
<th>Strongly Agree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N = 28)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust Plans</td>
<td>4</td>
<td>18</td>
<td>32</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>Trust Policy</td>
<td>4</td>
<td>18</td>
<td>46</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>People/services that are performing exceptionally</td>
<td>0</td>
<td>39</td>
<td>43</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Praise</td>
<td>7</td>
<td>36</td>
<td>28</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Points for action</td>
<td>0</td>
<td>21</td>
<td>46</td>
<td>29</td>
<td>4</td>
</tr>
</tbody>
</table>

Trust Newsletter

Only 32% of participants agreed that they regularly received the Trust Newsletter. Furthermore, only 21% of people agreed that they would know how to submit information to be featured in the Newsletter (Table 7).

Table 7 Trust Newsletter Responses

<table>
<thead>
<tr>
<th>How much do you agree or disagree with the following statements?</th>
<th>Strongly disagree (%)</th>
<th>Disagree (%)</th>
<th>Neither agree or disagree (%)</th>
<th>Agree (%)</th>
<th>Strongly agree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I regularly receive the Trust Newsletter (N = 28)</td>
<td>14</td>
<td>32</td>
<td>21</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>I know how to submit information to be featured in the Trust Newsletter (N = 29)</td>
<td>24</td>
<td>35</td>
<td>21</td>
<td>21</td>
<td>0</td>
</tr>
</tbody>
</table>
General Communication Process

The results indicated that 86% or more of the participants felt that internal communication within the Trust was at best only sometimes a two-way process, clear and understandable, regular, relevant, open, and accessible, (See Table 8).

Table 8 General Communication Process responses

<table>
<thead>
<tr>
<th>To what extent is communication within the Trust:</th>
<th>Never (%)</th>
<th>Rarely (%)</th>
<th>Sometimes (%)</th>
<th>Nearly Always (%)</th>
<th>Always (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A two-way process (N = 28)</td>
<td>18</td>
<td>36</td>
<td>46</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clear and understandable (N = 29)</td>
<td>7</td>
<td>48</td>
<td>38</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Regular (N = 29)</td>
<td>10</td>
<td>38</td>
<td>38</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Relevant (N = 29)</td>
<td>7</td>
<td>24</td>
<td>55</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Open (N = 29)</td>
<td>21</td>
<td>38</td>
<td>31</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Accessible (N = 28)</td>
<td>7</td>
<td>43</td>
<td>40</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

Satisfaction with communication about different information

Overall, participants reported more dis-satisfaction than satisfaction (see Table 9). The highest percentage of participants (34%) reporting that they were mostly satisfied or satisfied was in relation to the communication of information about Trust Policies, however 45% of the participants were still dissatisfied with this. Participants appeared to be most dissatisfied with communication about recruitment (76% mostly or very dissatisfied) and service development and change (76% mostly or very dissatisfied). In general it appears that staff were not very satisfied with the communication process or the communication of information.
<table>
<thead>
<tr>
<th>Please state how satisfied you are with the following:</th>
<th>Very dissatisfied (%)</th>
<th>Mostly dissatisfied (%)</th>
<th>Neither satisfied or dissatisfied (%)</th>
<th>Mostly satisfied (%)</th>
<th>Very satisfied (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication about job roles and responsibilities (N = 28)</td>
<td>21</td>
<td>32</td>
<td>18</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Communication about Trust Policies (N = 29)</td>
<td>7</td>
<td>38</td>
<td>21</td>
<td>31</td>
<td>3</td>
</tr>
<tr>
<td>Communication about service development and change (N = 29)</td>
<td>38</td>
<td>38</td>
<td>0</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Communication of information specific to Team (N = 29)</td>
<td>28</td>
<td>28</td>
<td>24</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Communication about recruitment (N = 29)</td>
<td>31</td>
<td>45</td>
<td>14</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Communication about the Strategy Business Plan (N = 29)</td>
<td>21</td>
<td>28</td>
<td>34</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Team Brief (N = 28)</td>
<td>11</td>
<td>29</td>
<td>32</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Trust Newsletters (N = 29)</td>
<td>3</td>
<td>42</td>
<td>38</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Accessibility of information (N = 29)</td>
<td>10</td>
<td>31</td>
<td>45</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Opportunity to feedback (N = 29)</td>
<td>17</td>
<td>28</td>
<td>38</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Response to staff feedback (N = 28)</td>
<td>36</td>
<td>29</td>
<td>21</td>
<td>14</td>
<td>0</td>
</tr>
</tbody>
</table>
DISCUSSION

This research aimed to investigate staff perceptions of internal communication in four CMHTs within an NHS Trust. It looked at whether recommendations from the Communication Policy and Staff Involvement Report (Department of Health, 1999) were being met in practice. The results showed that the Trust was not meeting all of the recommendations measured. Whilst the Trust used a variety of different methods to communicate with staff and provided Team Meetings on a monthly basis, the five principles of the Team Brief outlined in the Communication Policy were not being met. The Team Brief was generally not communicated face-to-face by line managers or at Team Meetings, did not occur on a monthly basis and was not seen as an opportunity for feedback. Furthermore, staff were generally not receiving the Trust Newsletter and were not aware of the process for submitting information to be featured in it. The majority of participants felt that the communication process was at best only sometimes a two-way process, clear and understandable, regular, open, and accessible. Finally, participants were generally dis-satisfied with internal communication.

A limitation of the research was the low response rate and consequently small sample size. It was difficult to estimate how representative the participants were of the whole sample as many did not report their profession. Participants may have left this out as they were concerned about remaining anonymous as only a small area was sampled. It is possible that individuals who were unhappy with communication may have been more motivated to complete the questionnaire than individuals who were satisfied or had little to say about communication processes. The results cannot be generalised to the whole Trust and it is possible that different results would be obtained in different areas or services within the Trust. Further similar studies could be conducted to provide this information.

It is important to consider the results of the present study in light of the context of the service at the time the research was conducted. The services were in the process of a major re-organisation that will have impacted upon communication processes. It is possible that the timing of the research resulted in more negative responses from
participants. Replication of the study at different times could investigate this further. Participants' responses to questions about the content of the Team Brief may be considered less valid if they were not receiving it. A large percentage of individuals held no strong opinion about the content of the Team Brief possibly because it was not effectively communicated. A future study could specifically ask whether individuals read Team Brief.

The results from the present study can be used to inform service delivery, whilst bearing the limitations in mind. The finding that the Team Brief is not being communicated as recommended in the Communication Policy may need further exploration. One reason for this may be because senior staff were not aware of the recommendations, or it might be that it is not practicable to meet these recommendations and they may need to be adjusted. If the Team Brief is felt to be an important method of communication, services may need to consider whether e-mail is an effective medium for this. It may be that staff do not prioritise reading Team Brief if it is sent via e-mail and that this needs to be communicated face-to-face to ensure all staff have an opportunity to feedback. Similarly, if the Trust Newsletter is considered to be important, the Trust should take action to ensure that individuals receive it, and consider again whether the Intranet or e-mail is an effective medium for communicating information.

Reports of exceptional performance and praise are important for improving staff morale which impacts upon the delivery of services, (Department of Health, 2003). Few participants' felt that the Team Brief included information about people or services performing exceptionally and opportunity for praise. If this information was not being communicated then it is important to investigate why this was not occurring, and the potential implications this has for staff morale and service delivery.

Finally, the finding that staff were generally dis-satisfied with internal communication is of concern because effective communication is considered vital for the success of organisations, (Department of Health, 2002). It is important that the internal communication process is looked at within these services and the findings of this research utilised to improve communication and make changes. Staff may feel more
satisfied with communication if the policy and recommendations are adhered to. Once these changes have occurred, this audit could be repeated.
REFERENCES


Appendix 1: Trust’s Communication Policy

(Internal Communication Section only)
Communications Policy

1. Introduction
To be efficient and effective needs excellent internal and external communications. Clear external communications only works when those running and working for an Organisation understand the agreed strategies and goals. Clear internal understanding leads to clear messages being communicated externally - it is an ongoing cycle.

2. Internal communications

All staff members have a line manager. The line manager must make sure that staff have a clear understanding of their role and responsibilities. Staff should have a regular team meeting or a one-to-one meeting with their line manager. At these meetings a monthly update from the various Directorates, known as 'Team Brief' will be communicated in addition to local information specific to the team. This is to ensure that staff have a wider understanding of the organisation's plans and objectives so that they can further understand the context of their work.

2.1 Intranet

has an intranet. The Intranet is an internal information tool. All departments and units within have a section where they themselves are able to publish relevant and up to date information. Each department/Unit has a staff member trained in publishing material to the intranet. The Communications Team also provides centralised support and guidance.

The Phone Directory is available via the intranet, and is updated monthly by the Communications Team.

2.2 Team Brief

Team Brief is a monthly update which outlines the progress of projects within the Trust. It is issued to Directors, Corporate Heads and Senior Operational Managers on the 4th Thursday of each month. They then communicate this update at their staff meetings. It is not appropriate to communicate Team Brief by only pinning the handout on a notice board alone. Line Managers should make a note of the issues raised by their teams, complete the staff feedback form and send it to the appropriate Director if the feedback is specific to a project, or if it concerns the process of compiling and communicating Team Brief it should be sent to the Communications
Team within the deadline specified on the form. Team Brief is based on six principles, these are:

- Issued on a monthly basis
- Presented face-to-face by line manager
- At team meetings
- About relevant issues
- Provides an opportunity for feedback

2.3 Information for Team Brief

Information for Team Brief should be either submitted to your Line Manager or Director, who will approve it before passing it to Communications. In addition Communications staff also attend a variety of meetings where issues of interest are noted and included in Team Brief.

Information for Team Brief should be subject matter that you think everyone in the Trust will be interested in or that they need to know. You may find it useful to use the five "P"s to decide if your item is suitable for Team Brief. These are:

- Plans
- Policy
- People
- Praise
- Points for action

If you are unsure, please ring the Communications Team (Ext ) who will be happy to discuss your item with you.

2.4 Newsletter

An online newsletter called News & Views will be produced for staff as well as external representatives and organisations. Staff are encouraged to contact the Communications Team about any news from their area, this could be ordinary people doing extra-ordinary things, new clinical developments or perhaps a service or a person that would benefit from a feature in the newsletter. Please email or ring the Communications Team with your ideas or suggestions. (T: )

News & Views will be produced in a magazine format and will be available on the Intranet and Internet and hard copies will be available on request from the Communications Team.

2.5 Other Newsletters produced by the Trust

Any newsletters produced by departments within the Trust should be passed to the Communications Team so that we can support you in ensuring that your materials are in line with NHS brand guidelines and identity. We can also assist with editing, production and print and can provide a template for newsletters.
Each year the Trust develops a strategy business plan. A summary of this is produced to let staff, clients, carers and the general public know what the Trust does and outlines the Trust's plans for the coming year.

2.6 Recruitment literature

Recruitment literature will be issued to all potential staff or applicants. This will contain general information about the Trust and information that is locality specific.

3. External communication

(The remainder of the policy addressed External Communication which was not included in the study)
Appendix 2: Generation of Items for Questionnaire
Generation of Items for Questionnaire

In addition to the specific questions detailed below, each section contained space for participants to include any further comments or opinions, and there was also space at the end of the questionnaire for any comments in general.

Section 1
This section provided a measure of individuals’ awareness of the Communication Policy and contained 3 forced choice dichotomous yes/no questions.

Section 2
A list of different methods of communication was generated from the Communication Policy, The Staff Involvement Report (Department of Health, 1999) and brief discussions with staff. This section aimed to investigate how often the different methods were used to communicate information. A five point likert scale of never – always was selected to aid the analysis of results.

Section 3
An open-ended question about their preferred method of communication was chosen so as not to restrict individuals’ options, (Barker, Pistrang and Elliott, 2002). These responses were then coded into the following categories:

1. Written – e-mail or letter
2. Face-to-face – Team Meeting or via Line Manager
3. Both in writing (e-mail or letter) and face-to-face (at Team Meeting or via Line Manager)

Section 4
This section aimed to gather information about accessibility to information and contained seven open-ended questions about attendance at Team Meetings, access to e-mail and computers, and opportunities to meet with senior staff. The questions were left open-ended rather than restrict participants to set choices, however examples of how to respond were included as a guide. Individual’s responses were coded into categories of daily, weekly, fortnightly, monthly, rarely, never.

Section 5
This section aimed to measure the extent to which the principles of Team Brief were being met, and contained five questions. Participants rated each principle on a 5 point likert scale of never – always.

Section 6
This section aimed to measure the extent to which the content of Team Brief contained the information suggested in the Policy. There were six statements about the content of Team Brief. Participants were asked to rate their agreement using a 5 point bipolar likert scale from strongly disagree – strongly agree.

Section 7
Two statements were included in this section about the Trust Newsletter. They were taken from the Trust’s Communication Policy. Participants rated their agreement on a 5 point likert scale from strongly disagree – strongly agree.

Section 8
This section contained seven characteristics of the communication process in general and participants rated each characteristic on a 5 point likert scale of never – always.

Section 9
This section elicited satisfaction with the range of different types of information communicated. The types were generated from the Communication Policy and Staff Involvement Report (Department of Health, 1999). Participants were asked to rate their satisfaction on a 5 point likert scale of very dissatisfied to very satisfied. Participants were also asked two open-ended questions about what they liked the best and least about communication within the Trust.

Section 10
This section gathered demographic information, including profession, grade, and length of time working in the CMHT and Trust. Individual’s age, sex and the team they worked for were not requested to ensure anonymity.
Appendix 3: Questionnaire “Are we communicating effectively?”
Are we communicating effectively?
ARE WE COMMUNICATING EFFECTIVELY?

This is a questionnaire about internal communication within Surrey Oaklands NHS Trust. This is an opportunity to make your experiences and views known. After the audit has been completed, a report will be sent to the Trust and each CMHT.

Please be assured that the information you provide will be treated confidentially. Your answers are anonymous, and no-one in the Trust will see your questionnaire. You should not put your name anywhere on the questionnaire.

When completing the questionnaire, please select the answer that comes closest to your opinion, or best applies to you. Please be as honest as you can.

When completed, please return the questionnaire in the addressed internal mail envelope provided as soon as possible.

Thank you for completing this questionnaire.
ARE WE COMMUNICATING EFFECTIVELY?

Section 1
This section asks about your familiarity with Communication Policy

1. Were you aware that the Trust has a Communications Policy? Yes No
   (Please circle your answer)

2. Have you read the Trust's Communications Policy? Yes No
   (Please circle your answer)

3. Would you know where to find this policy? Yes No
   (Please circle your answer)

Section 2
This section asks about how information is communicated to you.

<table>
<thead>
<tr>
<th>To what extent is information communicated:</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Nearly Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Face to face – individually with Line Manager</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Face to face – with representative for Line Manager</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Face to face – from colleague</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Face to face – in Cascade meeting, NOT Team Brief</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Face to face – at Team Meeting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. By e-mail</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Letter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Phone call</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. On bulletin boards – Trust website</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. On bulletin boards – on wall in place of work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Away days</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Other (please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please add any additional comments or opinions about how information is communicated.
Section 3

This section asks about your preferred communication method

Please specify how you would like information to be communicated to you


Section 4

This section asks about how you are able to access information that is communicated

How often are you able to access e-mail? (Please specify e.g. daily, weekly etc)

How often do you actually access e-mail? (Please specify e.g. daily, weekly etc)

How many people do you share a computer with? (Please specify the number)

How often are Team Meetings held? (Please specify e.g. daily, weekly etc)

How often are you able to attend Team Meetings? (Please specify e.g. daily, weekly etc)

How often do you have a one-to-one meeting with your line manager? (Please specify e.g. daily, weekly etc)

How often do senior staff/managers meet with you and listen to your views? Please specify e.g. daily, weekly etc)
怎么回事

Section 5

This section asks about how the Team Brief occurs

<table>
<thead>
<tr>
<th>Please answer the following in relation to your own experience of Team Brief:</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Nearly Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Brief is communicated face to face individually</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief occurs in Teams</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief occurs on a monthly basis</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief is an opportunity for feedback - from Management</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief is an opportunity for feedback - to Management</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Please add any additional comments/opinions about how the Team Brief is shared with staff.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section 6

**This section asks about the content of the Team Brief**

<table>
<thead>
<tr>
<th>To what extent do you agree with the following statements?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Team Brief contains information about relevant issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief contains information about Trust Plans</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief contains information about Trust Policy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief contains information about people/services that are performing exceptionally</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief is an opportunity to give praise</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Team Brief contains information about Points for action</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please add any additional comments/opinions about the content of Team Brief.

### Section 7

**This section asks for your opinions about the Trust Newsletter**

<table>
<thead>
<tr>
<th>How much do you agree or disagree with the following statements?</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I regularly receive the Trust Newsletter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I know how to submit information to be featured in the Trust Newsletter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please add any additional comments/opinions about the Trust Newsletter:
Section 8

This section asks for your opinions about the Trust's communication process in general

<table>
<thead>
<tr>
<th>To what extent is communication within the Trust:</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Nearly Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>A two-way process</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Clear and understandable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Regular</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Relevant</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Open</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Accessible</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please add any additional comments:

Section 9

This section asks about how satisfied you are with the different aspects of the communication process in the Trust

<table>
<thead>
<tr>
<th>Please state how satisfied you are with the following:</th>
<th>Very dissatisfied</th>
<th>Mostly dissatisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Mostly satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication about job roles and responsibilities</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication about Trust Policies</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication about service development and change</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication of local information specific to individual Team</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication about recruitment</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication about the Strategy Business Plan</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Brief</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust Newsletters</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility of information communicated</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunity to feedback</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to staff feedback</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please add any additional comments/opinions:
Please list at least one thing that you like best about communication within the Trust.

Please list at least one thing that you like the least about communication within the Trust.

Section 10
This section asks for some details about you

Please state your profession and grade: _______________________

Length of time working in this CMHT: _______________________

Length of time working in this Trust: _______________________

This is the end of the questionnaire. Thank you very much for your help. If there are any comments you would like to make, please write them below.

Please return the questionnaire to in the addressed envelope provided via internal mail. Thank you.
Appendix 4: Letter of authorisation to complete research
Thank you for a copy of your proposed research questionnaire, which was reviewed at our most recent seniors meeting. I have circulated it to all seniors for their information and to make any comments they felt appropriate. However, the over-riding opinion was that we would welcome such a local study with regard to communication, and I hereby confirm my authorisation for the local study to be conducted.

Please do contact me if you require any further help or assistance,

Yours sincerely
Appendix 5: Completed Activity Record for Clinical Audit

Committee
Please complete all the sections in the form, using one form per activity.

**CONTACT PERSON:**
- Trainee Clinical Psychologist
  - Clinical Psychologist

**SERVICE AREA**
- Adult Mental Health

**TEL NO & PLACE OF WORK:**

**TITLE OF AUDIT ACTIVITY:**
An audit of the Trusts Communication Policy: An investigation of internal communication procedures in a selection of Community Mental Health Teams

**BRIEF OUTLINE OF ACTIVITY:**
The questionnaire has been designed based mainly upon NHS Trust's Communication Policy. All staff at the CMHTs will be sent a questionnaire. This will include information about the audit, the questionnaire and an addressed internal mail envelope to return the questionnaire in if the individual chooses to participate. Descriptive statistics will be produced including responses in percentages.

**START DATE:** February 2004
**DATE:** June 2004

**RATIONALE:**
Good communications within the NHS has been highlighted as essential (e.g. Shifting the Balance of Power within the NHS: Communications, February 2002). NHS Trusts have developed Communication Policies which provide guidelines to ensure that internal communication with staff is a two-way process in which information is exchanged and understood. Comparing actual practice with these existing standards forms part of the clinical audit cycle.
ACTIONS FOLLOWING THE AUDIT

After the audit has been completed, a report will be sent to the Trust. Furthermore, the results will be fed back to the Team Manager who will then share this report with the staff of each CMHT.

CHANGES AND IMPROVEMENTS IN CLINICAL PRACTICE

The overall aim of this audit is to improve the process of internal communication by examining how practice matches against guidelines presented in the Communication Policy. This may lead to action for improving areas highlighted as poor.

SIGNATURE

DATE
Appendix 6: Ethical Scrutiny Form
The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust's ethical committee.

Name of Supervisor: 

Signature of Supervisor: 

Name of Trainee: 

Title of SRRP: An audit of a local NHS Trust's Commissioning Policy. An investigation of internal communication procedures in four Community Mental Health Teams.

Date: 11th December 2003
Appendix 7: Participant’s Information Sheet
ARE WE COMMUNICATING EFFECTIVELY?

WHAT'S IT ALL ABOUT?

Good communication within the NHS has been highlighted as essential. NHS Trusts have developed Communication Policies which provide guidelines to ensure that internal communication with staff is a two-way process in which information is exchanged and understood. Comparing actual practice with these existing standards forms part of the clinical audit cycle. The questionnaire is based on NHS Trust's Communication Policy (Ref: ). Staff from a selection of Community Mental Health Teams (CMHTs) have been approached to participate in the audit.

WHAT DOES IT INVOLVE?

All you have to do is complete the attached questionnaire which contains 10 short sections about different aspects of NHS Trust's Communication Policy. This should only take between 5 and 10 minutes in total. This can then be returned to me via internal mail in the addressed envelope provided.

WHO IS CARRYING OUT THE AUDIT?

, a Trainee Clinical Psychologist from The University of Surrey, currently based at CMHT. The audit is supervised by Dr , Clinical Psychologist at, and Dr for the PsychD Clinical Psychology course at The University of Surrey. Development and implementation of this audit is part of the requirements for the PsychD in Clinical Psychology course.

WILL THE INFORMATION BE CONFIDENTIAL?

If you agree to complete the questionnaire, your reply will be completely confidential. No one else in the Trust will see your questionnaire. The results will be presented in a format that will ensure your identity is not revealed. The responses will be converted into numbers and entered onto a computer. You need not write your name on the questionnaire at any point.

WHY IS MY REPLY IMPORTANT?

This questionnaire gives you the opportunity to express your views and comment upon internal communication in the Trust. The success of the audit is dependent upon the good will and co-operation of those who take part. The more people who respond, the more accurate and representative the results will be. After the audit has been completed, a report will be prepared for the Trust. The results will be fed back to each Team Manager who will then share this with the staff of each CMHT. A copy of the report will be sent to each participating CMHT. If you wish to discuss any of the issues raised in this audit please contact Trainee Clinical Psychologist, (telephone number). If you require further information about the Communication Policy (Ref: ) please contact your Line Manager.

PLEASE RETURN BY 26TH MARCH 2004
Appendix 8: Instructions to be read out in Team Meeting
Please distribute the questionnaire to all staff (including secretarial and administration staff) in the CMHT.

TO BE READ OUT IN THE TEAM MEETING

This is a questionnaire looking at NHS Trust's Communication Policy. A Trainee Clinical Psychologist has requested that all staff be given one of the questionnaires at a Team Meeting. Once completed the questionnaire can be returned via internal mail in the envelope provided. Further information about the questionnaire is included in an accompanying Information Sheet.

This questionnaire gives you the opportunity to express your views and comment upon the internal communication in the Trust. It should only take about 5 minutes to complete, and the success of the audit is dependent upon the good will and cooperation of those who take part.

Thank you for reading this out. Please could all staff not at the Team meeting be given a copy of the questionnaire with the minutes of the Team Meeting.
Appendix 9: Additional Comments participants made in questionnaire
Additional Comments/Opinions

After each section and at the end of the questionnaire individuals were provided with space to include additional comments or opinions. Every comment made on the questionnaire is included below, and each line represents a separate participant.

In Section 2
Comments or opinions about how information is communicated

<table>
<thead>
<tr>
<th>Comment</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than often from colleagues</td>
<td></td>
</tr>
<tr>
<td>Communication is often received late, or with too little time to arrange/plan to attend meetings.</td>
<td></td>
</tr>
<tr>
<td>Communication is often confusing or sketchy</td>
<td></td>
</tr>
<tr>
<td>Communication is mainly a one-way dialogue from up to down.</td>
<td></td>
</tr>
<tr>
<td>It is difficult to answer these questions as I do not know how fully information is given or how accurately.</td>
<td></td>
</tr>
<tr>
<td>Team Brief should be discussed at Team Meeting to ensure it gets attention and feedback.</td>
<td></td>
</tr>
<tr>
<td>E-mail has reached ridiculous proportions, it’s a waste of time sending everything, give us back choice. If I want to know I can find out. Whatever happened to people speaking to each other!! How did we manage before e-mail!!</td>
<td></td>
</tr>
<tr>
<td>I have a feeling that only partial information is shared. It is difficult to know how good the communication is unless I know what the original message was.</td>
<td></td>
</tr>
<tr>
<td>Managerial and clinical supervision is also a forum for the communication of information as is senior nurse meetings.</td>
<td></td>
</tr>
</tbody>
</table>

In Section 3

How would you like information to be communicated to you?

Key for coding:
1 = In writing – e-mail or letter
2 = Face-to-face at Team Meeting or via Line Manager
3 = Both in writing (e-mail or letter) and (face-to-face at Team Meeting or via Line Manager)

<table>
<thead>
<tr>
<th>Comment</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>E - mail, letter</td>
<td>1</td>
</tr>
<tr>
<td>Team Meeting</td>
<td>2</td>
</tr>
<tr>
<td>Face to face at Team Meeting</td>
<td>2</td>
</tr>
<tr>
<td>Team Meeting and e-mail</td>
<td>3</td>
</tr>
<tr>
<td>Face to face and written</td>
<td>3</td>
</tr>
<tr>
<td>Meetings</td>
<td>2</td>
</tr>
<tr>
<td>Line Manager at Team Meeting and e-mail</td>
<td>3</td>
</tr>
<tr>
<td>Face to face at Team Meeting</td>
<td>2</td>
</tr>
<tr>
<td>Face to face</td>
<td>2</td>
</tr>
<tr>
<td>Team Meeting</td>
<td>2</td>
</tr>
<tr>
<td>Method</td>
<td>Frequency</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Face to face</td>
<td>2</td>
</tr>
<tr>
<td>Letter then face to face in Team Meeting or individually</td>
<td>3</td>
</tr>
<tr>
<td>e-mail and face to face</td>
<td>3</td>
</tr>
<tr>
<td>Face to face at Team Meeting</td>
<td>2</td>
</tr>
<tr>
<td>e-mail and face to face at Team Meeting</td>
<td>3</td>
</tr>
<tr>
<td>Letters and face to face</td>
<td>3</td>
</tr>
<tr>
<td>face to face</td>
<td>2</td>
</tr>
<tr>
<td>Team Meeting and line manager</td>
<td>2</td>
</tr>
<tr>
<td>face to face</td>
<td>2</td>
</tr>
<tr>
<td>Line manager</td>
<td>2</td>
</tr>
<tr>
<td>e-mail and line manager</td>
<td>3</td>
</tr>
<tr>
<td>e-mail direct from the individual wanting to communicate with you.</td>
<td>1</td>
</tr>
<tr>
<td>e-mail and letters</td>
<td>1</td>
</tr>
<tr>
<td>Letters</td>
<td>1</td>
</tr>
<tr>
<td>face to face followed up in writing</td>
<td>3</td>
</tr>
</tbody>
</table>

**In Section 4**

Comments or opinions about the accessibility of information that is communicated

**Comment**

It is disappointing that during the recent Trust changes that this Team had no permanent manager to support/direct the team. It is the Team most affected by the changes and communication was lacking. It would have been appropriate for higher management and H.R. to make some special visit to this team and to speak to the groups of professionals who were to be affected and be treated as a “special case” regarding communication. It is ridiculous of management to expect a Team Leader to cover 2 areas appropriately at this time.

There is a lack of communication, especially due to NHS relocation of staff etc.

Senior staff/managers never listen as they don’t want to hear our views!!

**In Section 5**

Comments or opinions about how the Team Brief is shared with staff

**Comment**

I am unable to attend Team Brief Meetings

Usually via e-mail.

It’s the responsibility of staff to read.

I’m not very aware of Team Brief

Very rarely, I don’t even know if it still exists.

By e-mail but I have no time to look at this.

Team Brief is posted on e-mail so you can only see it if you are able to use the computer and take responsibility to view it yourself. (Some Team members are unable to use computer.)

Team Brief rarely provides new information, most of the information is vague and out of date.

E-mail only

Team Brief is not communicated face to face individually by the Line Manager anymore
Team Brief used to occur at Team Meetings but not anymore.
Team Brief is communicated via e-mail/personal or via bulletin board

We need to bring Team Brief into an arena for discussion, get it into Team Meetings or business meetings.
Via e-mail not face to face
Team Brief comes via the Intranet.

Haven’t seen it for a long time. We used to have it on display but can’t see it at the moment.
Through e-mail. Printed from computer by CMHT secretary and posted on bulletin board.

In Section 6
Comments or opinions about the content of the Team Brief

Comment
I think that feedback on praise and exceptional performance relies on staff members so is under represented.
I don’t know if it still exists
I rarely look at Team Brief
Information is usually out of date or very vague
Since it went electronic it’s gone missing

In Section 7
Comments or opinions about the Trust Newsletter

Comment
It’s another piece of paper
It should be combined in Team Brief every 3 months to save printing costs
I was not aware of a Trust Newsletter
I never receive it.
How much does it cost to produce? What is it’s value to us?

In Section 8
Comments or opinions about the Trust’s communication in general

Comment
There is a lack of communication
I think communication is poor overall
Poor!
I feel the Trust makes a lot of decisions and don’t tell staff until after.
Communication appears to be a two-way process theoretically but it often seems to be a lip-service exercise when it appears that decisions have already been made.
This Trust communicates one way!!
In Section 9
Comments or opinions about satisfaction with different aspects of communication within the Trust

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff tend to verbally say their opinion but don’t actually do anything more.</td>
</tr>
<tr>
<td>Staff morale is very low and most colleagues feel isolated from Management.</td>
</tr>
<tr>
<td>On e-mail we are bombarded with irrelevant things to us – and there is only so much time you can take to read things. As we share computers, you cannot always “hog” the computer (which is very slow and outdated). It is better for a manager to sift out information and give us relevant information at a Business meeting (which we don’t have) and more cost effective than clinicians having to wade through information.</td>
</tr>
<tr>
<td>There is little evidence that managers are taking on board any concerns.</td>
</tr>
<tr>
<td>Communication about service development and change is terrible in this Trust</td>
</tr>
<tr>
<td>Lack of opportunity to give views – but concerns about validity of doing so to management.</td>
</tr>
</tbody>
</table>

One thing you like the most about communication

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most information is pretty clear</td>
</tr>
<tr>
<td>Nothing</td>
</tr>
<tr>
<td>That there is a regular system i.e. Team Brief.</td>
</tr>
<tr>
<td>There is an emphasis on good communication.</td>
</tr>
<tr>
<td>Good communication within Team locally</td>
</tr>
<tr>
<td>That there is some</td>
</tr>
<tr>
<td>Nothing/No comment</td>
</tr>
<tr>
<td>E-mail is useful</td>
</tr>
<tr>
<td>My colleagues communication</td>
</tr>
<tr>
<td>?</td>
</tr>
<tr>
<td>Access to website</td>
</tr>
<tr>
<td>CMHT Team Meetings</td>
</tr>
<tr>
<td>The relationship I have with my Line Manager.</td>
</tr>
<tr>
<td>Team and Business meetings, and e-mail</td>
</tr>
<tr>
<td>Sometimes are sent letters</td>
</tr>
<tr>
<td>E-mail</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>E-mail</td>
</tr>
<tr>
<td>The use of the Intranet and e-mail</td>
</tr>
<tr>
<td>E-mailing has improved speed and directness of communication</td>
</tr>
<tr>
<td>Varied ways of communication and opportunity to feedback</td>
</tr>
</tbody>
</table>

One thing you like the least about communication

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of access to computers makes checking e-mail very difficult</td>
</tr>
</tbody>
</table>
Junior Doctors have received little information regarding major changes within the trust structure and their clinical role.

It is often difficult to establish the validity of verbal information.

Sometimes information is contradictory or changes too rapidly to keep up to date.

Platitudes

Rumours. There seems to be a lot of them

Communication is very poor and staff are undervalued and demoralised

Doesn’t seem to be the whole truth, just the bits they want us to know.

Not being listened to and generally not being valued as an individual and part of the Trust.

Any communication is incomplete information

It ‘pretends’ to listen and take note of employees comments and views.

It tends to be informing rather than communicating.

Joint Meetings with Managers tend to be irrelevant and unproductive.

The belief that the Trust is not fully committed to a two way process and “spins” information it gives

Unreliable

Too much unnecessary paper

Decisions are made and those at the bottom of the hierarchy are last to hear, even when it affects them.

Management plans to change or axe a service without talking to the staff that run that service

Communication about changes

Play lip-service to listening to staff opinions.

The feeling that the trust only plays lip-service to its need to communicate and share ideas.

There does not appear to be a formal way in my CMHT for communicating information. It seems to be rather ‘hit and miss’. Information is sometimes inaccurate as it goes though so many people.

The amount of information communicated is sometimes difficult to absorb and retain.

Some information received through the e-mail are not always necessary or relevant to every member of staff.

Individuals seem to have different views on the same subject which leads to confusion when conveying things.

Additional comments

Comment

Communication with me about funding for my post was very unreliable and left to the last minute.

As stated before, general feeling overall with the majority of colleagues is undervalued, not important second class manual workers for middle class management.

The Trust decides upon a communication board in each CMHT. This information cannot be counted upon being the truth.

Start communicating honestly.

This is a waste of time and paper. Good Luck.
Appendix 10: Evidence that information fed back to the services (to be added when completed)
Dear

Re: Communication Audit Report – CMHT

Thank you for sending me a copy of the summary of the communication audit conducted whilst you were on placement at CMHT. I have shared the summary with the Senior Clinical Staff members of the Team at our Senior Staff meeting in January ’05. The Audit was detailed and gave us some very interesting feedback with regard to how we communicate information locally, also baseline information as to how effective these processes were, giving an indication as to the satisfaction levels of staff with this process. The recommendations included in the summary have been most useful and as Senior members of this Mental Health Team we are now looking as to how we can improve our local communication processes.

It was a most valuable piece of work, timely, which has certainly given rise to local debate and for us as a team to examine our local communication processes.

Many thanks for your work,

Yours sincerely,

[Signature]

Primary Care Mental Health Team Co-ordinator
MAJOR RESEARCH PROJECT

Young people's experiences of attending solution focused brief therapy: an interpretative phenomenological analysis

Year 3: July 2004
ACKNOWLEDGEMENTS

I would especially like to thank all of the young people who took the time to participate in the research and share their experiences of attending solution focused brief therapy. I would also like to thank their parents who supported them to take part in the study.

I am most grateful to Mary John for the support and commitment that she has provided during the development and completion of this study, and would especially like to thank her for keeping me grounded and having confidence in my ability. I would also like to thank Alex Proto and Ann Kimber for supporting the development of the research, providing the setting for the research and for helping with recruiting participants. I am grateful to my peers, Naomi Dawkins, Louise Dennis, Rachel Silva, Tarick Ali, Ella Fuller, Amy Taylor, Luanne Mason, Danielle McClymont, and Suzanne Winn, who formed a group of qualitative researchers, conducting credibility checks and providing invaluable advice, support and friendship during the research process. I would also like to thank my research supervisors and friends for taking the time to proof read the research.

Finally, I would like to thank my family and partner, Ben Abbott, for sticking by me and helping me to remain focused and committed when I needed this the most.
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ABSTRACT

Objectives: To explore young people’s experiences of attending a Solution-Focused Brief Therapy (SFBT) clinic, and the meanings they attribute to this experience.

Design: A qualitative research method, Interpretative Phenomenological Analysis, was employed to analyse and interpret young people’s verbal accounts of their experiences, gained during semi-structured interviews.


Participants: Eight young people aged between 11 and 17, who were attending or had recently completed SFBT.

Main Outcome Measure: The interviews were audio-taped and transcribed. A process of systematic analysis proceeded and a number of main themes emerged.

Results: The young people sought help to overcome problems and found attending the clinic, at first, anxiety provoking. They experienced the development of a therapeutic relationship and the therapist’s personality and attitude were important. The therapist was active in the process, providing advice and solutions. Facilitative factors included certain SFBT techniques (problem-free talk, complimenting, scaling), client motivation, support from others, and a goal-focused and realistic approach to change. The experience impacted upon the young people in many ways beyond their defined goals. Having some control over the process of therapy was important, and this led to a sense of control over their future and difficulties.

Conclusions: The young people experienced the creation of a setting whereby successes could be celebrated, and valued praise from the therapist. Self-motivation, feeling actively included and being able to be in control of the therapy process were central to their experience.
1. INTRODUCTION

1.1 Introducing the research

Solution-Focused Brief Therapy (SFBT) evolved during the 1980’s from within the family therapy and systemic arena (de Shazer & Berg, 1997). The SFBT model is recognised by its emphasis on the construction of solutions rather than problem-solving (Iveson, 2002). Historically, problem-solving approaches have dominated the practice of psychotherapy. In contrast, SFBT emphasises the strengths and personal resources of the clients and their ability to find solutions to their difficulties. Their own views of the process of change and what is helpful are therefore central. Evan George, Chris Iveson, and Harvey Ratner established the Brief Therapy Practice in the UK in 1989. The SFBT model has many features that may be particularly child friendly including the non-blaming attitude, a focus on exploring times when the problem is not present and the use of concrete language (Lethem, 2002). In the current study, I explored young people’s (aged 11-17) perceptions of SFBT, by analysing their accounts of the experience of attending SFBT. Underlying the SFBT model is the philosophy that “the client is the expert in developing his/her own solutions” (Metcalf & Thomas, 1994; pp. 51). In line with this philosophy, I aimed to gain insight into young people’s views of the meaningful and helpful aspects of SFBT, and their views of the process of change.

In line with the current emphasis on evidence-based practice within the NHS, researchers have begun to evaluate the effectiveness of SFBT by measuring outcomes. However, the client’s perspective needs to be recognised and included, especially as this is an inherent emphasis within SFBT (de Shazer & Berg, 1997). Qualitative methods are increasingly being used to research clients’ experiences and perceptions of psychotherapy and are appropriate for answering research questions that focus on the exploration of experiences and the understanding of meaning (Dallos & Vetere, 2005). Young people’s views of psychotherapy have rarely been sought and recent government guidelines emphasise the

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1 I have chosen to refer to myself in first person to facilitate the process of self-reflexivity that is important in a qualitative study of this nature.
importance of seeking, and attempting to understand, young people’s experiences (Department of Health, 2004). Qualitative approaches enable the participants’ voices to be heard and exploration of areas of importance to them as well as the researcher. The findings of this study can be used to encourage more effective and meaningful therapy for young people, whilst also providing an opportunity for young people to express their views about what it is like to attend SFBT.

1.2 SFBT: background and assumptions

Steve de Shazer and his colleagues “were interested in finding out what differences made a difference” (De Shazer & Berg, 1997; pp. 121). They studied the most effective and efficient ways to assist clients, by understanding what was helpful from the client’s perspective (de Shazer, 1991). Insoo Kim Berg, the co-founder of SFBT, described how she became interested in brief therapies as a result of her own experience that many individuals drop out of intensive longer-term psychotherapy. Research also suggested that many individuals were in fact seeking brief approaches which would be helpful to them immediately rather than months or years down the line (Berg, n.d.). De Shazer, (1991) describes the development of the SFBT model as starting with researchers attempting to find out what therapists can do to help people, and then moved on to focus on what clients do to find solutions to their difficulties.

De Shazer and his colleagues were influenced by the work of the Brief Therapy team at the Mental Research Institute (MRI) (George et al. 2002). The MRI encourages the use of an interactional approach which aims to alter the relational patterns maintaining the problems that clients are struggling with. This approach has been described as employing a problem-focused model (Jordan & Quinn, 1994). De Shazer and his colleagues were initially interested in problem patterns and the solutions that often serve to maintain these patterns. The focus of their work changed as they became interested in the inconsistencies in the problem pattern, when the problem is less severe or absent. They also discovered the importance of asking clients about their own hopes for the future, and
found that this reduced the length of therapy. George et al. (2002) suggest that these important foci led to the development of the two ‘main pillars’ of SFBT. Firstly, regardless of the type of problem, there will always be exceptions or times when the problem is less severe or absent. Secondly, identifying client’s hopes for the future encourages them to focus on where they want to get to, in the immediate and longer term future, rather than attempting to understand the past. In Box 1, the “essence” of SFBT as described by George et al. (2002) is presented.

Box 1: The essence of SFBT

- To work with the person rather than the problem
- To look for resources rather than deficits
- To explore possible and preferred futures
- To explore what is already contributing to those possible futures
- And to treat clients as the experts in all aspects of their lives

George et al. (2002; pp. 2).

George et al. (2002) also describe the assumptions of SFBT which they suggest guide therapists in the direction of effective intervention. These are summarised in Box 2.
Box 2: Assumptions of SFBT

1. Attempting to understand the cause of a problem is not a necessary or useful step towards resolution.
2. Successful work depends on knowing where the client wants to get to, and finding the quickest way there.
3. However fixed the problem may appear to be, there are always times when the client is doing some of the solution.
4. Problems do not represent underlying pathology. They are just things that the client wants to do without, and therefore the client is the best judge of when the problem is resolved.
5. Sometimes only the smallest of changes is necessary to set in motion a solution to the problem.
6. It is the task of the therapist to determine the client’s unique way of co-operating with the work and fit with this.

(George et al. 2002; pp 18)

1.3 SFBT techniques

SFBT employs a number of techniques. The first session is particularly important and each session is treated as potentially the last. In the first session the therapist introduces and encourages the shift from problem-saturated to solution-focused conversations. Problem-saturated stories are focused on deficits and problems, and are the stories that clients present to the therapist which suggests that the problem is so dominant that other areas of their identity or life, including times when the problem is less severe or absent, become marginalised (Monk et al. 1997). The aim in the first session is to initiate conversations with the client which enable them to be an active part of the therapeutic process and for the therapist to ‘connect with the person’ (George et al. 2002). Specifically, the therapist is interested in finding out about the individual rather than about the problem. The aim is to create a context whereby competence can be discussed and the client can be acknowledged as separate from the problem. SFBT practitioners
utilise a number of techniques to achieve this including: problem free talk; goal clarification; exploration of preferred future; the miracle question; exploration of exceptions (when the difficulty is less of a problem or absent); scaling questions; and compliments. A more detailed description of these techniques is available in Appendix 1. At the end of the session, the client is given the choice as to whether further appointments would be useful and if so, when they think it would be helpful to return. Subsequent sessions are all treated as follow-up sessions whereby progress since the first session is explored (George et al. 2002).

1.4 Theory of change

Miller (1997) suggests that SFBT practitioners view problems and solutions as socially constructed realities. SFBT is considered to have no theory of what causes or maintains problems but instead is based on theories "about the nature of knowledge, the social construction of reality and the creative potential of language" (George et al. 2002; pp. 2). The approach acknowledges that individuals come to seek help with a socially constructed 'story' of the problem which has been constructed over time with others in the individual’s social context. Berg and De Jong (1996) suggest that approaches that are consistent with a social constructionist view promote change by allowing new views of reality to be acknowledged and explored. Other postmodern approaches share this social constructionist ideology, such as Narrative Therapy (e.g. White & Epston, 1990) but highlight the importance of de-constructing problem-saturated stories (Monk et al. 1997).

Deconstruction refers to a process whereby the individual is encouraged to explore all dimensions of the problems, how it first arose, the impact of it on their life and to question cultural assumptions or taken for granted beliefs that may have contributed to the construction of the problem (Monk et al. 1997). SFBT practitioners, in contrast, do not deconstruct the problem story as they suggest that repeated retelling of problem stories can be problematic as we learn who we are through the stories we tell about ourselves. George et al. (2002) argue that most clients expect professionals to be interested in their problem-saturated stories. The retelling of problem stories is thought to
result in the client viewing himself/herself as the problem and feeds into self-fulfilling prophecies (Miller, 1997). De Shazer and colleagues practicing SFBT have also suggested that discussion of the problem is not necessary or helpful and instead focus on constructing solutions without defining and de-constructing the problems. In SFBT, the focus is on the present and future rather than the past. Narrative therapists, on the other hand, are interested in the past, present and future, and attention is focused on deconstructing the problem-saturated story and allowing alternative narratives to emerge in contradiction to the dominant problem-saturated story (Monk et al. 1997). Therefore, within SFBT, the techniques mentioned above provide a structure and format which guides the conversations and what is spoken about in the sessions. Within narrative therapy the ‘thicker’ story is seen to emerge in a less structured manner, through deconstruction of the problem and discussions that allow individuals access to these alternative stories of their lives (White, 2004).

The SFBT approach has embedded within it the critical understanding and use of language, and how the process of conversation works to create change (George et al. 2002). De Shazer (1994) encourages therapists to use ‘solution-talk’ or ‘change-talk’. This includes asking questions which presuppose that change is occurring, questions that encourage clients to notice change in their lives which they have previously ignored, and holding detailed conversations about improvements that the client reports (McKeel, 1996). In SFBT, change is viewed as always present in our lives. Language and communication are acknowledged as important vehicles of change through the conversational process. George et al. (2002) suggest that the main therapeutic process in SFBT occurs through the therapeutic conversation which is created during the sessions through the use of techniques mentioned above. The aim is to shift clients from problem-saturated to solution-orientated conversations. SFBT assumes that solutions to problems are already present in the clients’ lives, but they have been unable to see the solutions whilst the focus is on the problem-saturated story.
SFBT has been criticised for the minimal attention and time dedicated during therapy for the discussion of, and understanding of, problems (Stalker et al. 1999). Piercy et al. (2000) argue that people may not feel heard and may dis-engage from therapy if they are directed to explore solutions when they are trying to talk about their difficulties. I was aware that in some ways I shared this view that individuals may have experiences of not being heard in SFBT, when the focus is directed away from talking about the problems. As a result of this, I became interested in narrative therapy approaches as the flexibility exists to explore and gain understanding of how problems evolved and impact on individual’s lives. Critics of SFBT (e.g. Coyne, (1994) and Nylund & Corsiglia (1994); cited in Wettersten et al. 2005) also suggest that SFBT focuses on the application of techniques at the expense of developing an effective therapeutic alliance. They argue that SFBT is too goal focused at the expense of the therapeutic relationship (Wettersten et al. 2005).

Critics of SFBT also often suggest that whilst SFBT practitioners claim that the approach brings about significant and enduring change, there are few well-controlled, methodologically sound studies into the efficacy and effectiveness of SFBT (Wettersten et al. 2005). Narrative Therapy has also been criticised as a result of the lack of well-controlled studies into its effectiveness and efficacy, which may have evolved as a result of the rejection of positivism upon which quantitative research is based. Dermer et al. (1998) criticise SFBT for overlooking gender and power differences and for the predominant focus on behaviour change in the absence of gaining insight or understanding. Narrative therapy, on the other hand pays closer attention to the context of gender, social class, race, sexual preference and culture and how these influence the dominant stories that we come to tell of our lives (Morgan, 2000). However, both SFBT and narrative therapy are commended for their focus on individuals’ resources and personal expertise, whilst attempting to avoid pathologising individuals.
1.5 **SFBT with children and adolescents**

The ideas and techniques of SFBT developed from work with families, couples and individuals. Lethem (2002) indicates that since the early 1990's a number of authors have described the use of SFBT with children and adolescents. SFBT has many features that may be particularly child friendly including the non-blaming attitude, problem-free talk and the concrete language utilised (Lethem, 2002). Wheeler (2001) describes how he has found the use of SFBT approaches relevant in his work within a Child and Adolescent Mental Health Service (CAMHS). In particular he suggests that SFBT can reduce problem saturation which may be common in child and family settings where the parents may be preoccupied with concerns about their child and/or may feel they have run out of effective strategies. This type of problem thinking often means that past successes are forgotten and their view of the future is bleak. Wheeler (2001) cites research which suggests that when approaching services, families are hoping for short term brief interventions, and thus SFBT may fit with their expectations.

1.6 **Review of research into SFBT**

De Shazer and colleagues state that SFBT developed within the framework of deductive research. The techniques were selected by ‘doing more of what works’ and abandoning approaches that were considered unhelpful from the perspective of both the therapist and the client. De Shazer and Berg (1997) suggest that they paid attention to both successes and failures during the development of the SFBT approach. They noted that, in their own follow-up work, they found that “SFBT is consistently successful – regardless of the client’s problem(s)” (De Shazer & Berg, 1997; pp. 122). However, the current emphasis on evidence-based practice within psychology and psychotherapy has led to a focus on rigorous objective evaluation of the effectiveness of different approaches. The focus has therefore been on finding out whether the SFBT approach makes a significant and lasting difference (Lethem, 2002). The majority of recent research into SFBT has consequently focused on evaluating its effectiveness through measuring outcomes (e.g. De Shazer, *et
Stalker et al. (1999) argue that there is little evidence of the efficacy of SFBT as very few methodologically sound studies have been conducted.

Early research mainly consisted of follow-up studies that looked at subjective reports from clients about whether they had met their goals or achieved significant progress (e.g. de Shazer, 1985; Lee, 1997; DeJong & Hopwood, 1996). They provided some initial support for the success of SFBT, but were criticised as they were predominantly from therapist-researchers within the Brief Therapy Centre (Stalker et al. 1999). Furthermore, these studies lacked experimental control and therefore causal inferences about the effectiveness of SFBT approaches could not be drawn from these studies (Gingerich & Eisengart, 2000).

Gingerich and Eisengart (2000) present a review of 15 available controlled outcome studies. These covered a range of populations and presenting problems such as: depression in female college students; parent-child conflict; and adolescent offenders. They categorised only 5 out of the 15 studies to be “well-controlled” and suggested that there were methodological problems in many of the studies. Whilst acknowledging the limited number of well-controlled studies, they conclude that preliminary support for the effectiveness of SFBT is emerging. Two of the 15 studies reviewed compared SFBT with an alternative psychotherapy and Gingerich and Eisengart (2000) suggest that there is a need for empirical research into SFBT to continue and for this to include comparisons with other therapeutic interventions.

As with most psychological therapies, a heavy emphasis has been placed upon establishing the effectiveness of the approach both in comparison to no treatment and to other psychotherapies, and on how well SFBT works with specific client groups and presenting problems. Larner (2004) indicates that the experimental rigour which is inherent within the scientist-practitioner model has meant that outcome data in the form of randomised-controlled trials has been considered the golden standard of research. Clinicians and researchers acknowledge the limitations of outcome studies in terms of
their ability to answer clinically relevant questions about what accounts for the success reported (McKeel, 1996). Many researchers argue for a more inclusive approach to evidence-based practice which includes qualitative research into why and how therapy works (Larner, 2004). One way in which this has been addressed is through exploratory research into clients’ and therapists’ experiences of therapy and change.

1.7 The common factors of psychotherapy

Lambert (1992/2003) highlights that 6 decades of research now exists in support of the effectiveness of psychotherapy, and that different therapies are equally effective. One explanation for the finding that a variety of psychotherapy approaches are equally effective, is that certain ‘common factors’ are responsible for improvement in psychotherapy. The common factors of therapy are described in Box 3:

![Box 3: Common Factors of Therapy](image)

(Lambert, 1992/2003; pp. 97)
Hubble et al. (1999) indicate that merely accepting that "common factors largely account for change is not enough" (pp. 408). The model and specific techniques of therapy do play a role, albeit smaller than other factors, in the change process. It is clear that the theoretical orientation does influence how problems (and clients) are thought about and understood (Maione & Chenail, 1999). It also seems likely that different therapeutic models may be effective through enhancing the common factors of therapy, and certain approaches may "capitalize on the contribution of the common factors" (Hubble et al. 1999; pp. 408). Bischoff and McBride (1996) suggest that exploring client perceptions of therapy may help to identify which factors lead to change.

1.8 Research into clients' experiences of therapy

Exploring client's perceptions of therapy may provide therapists with ideas about which aspects of therapy are meaningful to clients and contribute to successful therapy (Bischoff & McBride, 1996). Elliott and Williams (2003) stated that there continues to be a paucity of research from the client's perspective within psychotherapy, in comparison to research that explores the therapist's and researcher's perspectives. However, there are a number of researchers who have explored different aspects of the process of psychotherapy from the client's perspective using a variety of qualitative research methods. Research has varied in the foci that researchers have adopted, perspectives sought and the methods utilised to do this (Toukmanian & Rennie, 1992). Rennie (1992) for example, looked at client's experience of psychotherapy through exploring client's tape-replay-assisted recollections of the experience of an hour of therapy. He found that client's engage in a process of self-reflexivity during sessions that often remains covert to the therapist. Elliott & Shapiro (1992), on the other hand, explored the same significant event within therapy from the perspective of the client, therapist and an observer, highlighting the rich diversity between their experiences and understandings.

Researchers have also explored client's experiences of therapy as a whole rather than specific events or specific sessions. Within the field of family therapy, several researchers
have explored clients’ experiences of family therapy or aspects of these approaches (e.g. experiences of reflecting teams; Sells et al. 1994; cited in Walsh, 1997). Bischoff and McBride (1996) explored 28 adult clients’ experiences of attending couples and family therapy. Participants were interviewed during the course of individual, family or couples therapy. They found that clients experienced a hierarchy within the client-therapist relationship, deferring at times to the therapists agenda and viewing the therapist as an expert. They also found that the expert position of the therapist was only trusted when the therapist was also perceived to be understanding, empathic and promoting mutuality within the therapeutic relationship. However, the findings from this study are potentially limited as the participants were interviewed by their therapist which is likely to have impacted on participants’ responses, especially as therapy was ongoing at the time of the interviews. Further research conducted by interviewers who are not the therapist would increase the reliability of the findings (Bischoff & McBride, 1996).

1.9 Adult client’s experiences of SFBT

Metcalf and Thomas (1994) and Metcalf et al. (1996) explored experiences of SFBT as perceived by six couples and their therapists. They were interested in discovering how the client’s perception of therapy compares to that of the therapist, and what occurs in the therapy process that the clients and therapists perceived to be most helpful. They found that clients’ perceived the therapist to be directive, providing advice, making suggestions, and guiding them. They also experienced the therapist as focusing on them specifically, reinforcing their strengths and listening. Metcalf et al. (1996) found that therapists’ and clients’ perceptions differed. For example, clients commented on aspects of therapy that are known to lead to its effectiveness, such as the quality of the therapeutic relationship, whereas therapists were more likely to focus on specific techniques. They suggest that a consistent theme to emerge in their research was the client’s experience of a focus on client resources and the importance of the therapeutic relationship. They attempted to understand their findings through drawing on Lambert’s (1992/2003) ‘common factors’ of therapy and suggest that SFBT may be effective as the focus is on the resources,
competencies, strengths and successes of the client therefore contributing to the largest common factor, client variables.

Whilst Metcalf and Thomas (1994) looked at what the clients and therapists considered were influential factors in creating change, the research did not attempt to explore their experiences in depth, and mainly focused on the discrepancies between the therapists’ and clients’ perceptions of SFBT. Joel and Nelson (2004) have recently conducted analyses of 91 adult clients’ responses to structured questions about the helpful aspects of SFBT. The results suggested that clients found the therapy ‘helpful’, the therapists ‘quite helpful’, had few suggestions for improvement, described therapy in terms non-specific to SFBT and would recommend the therapy to others. This research provided a brief insight into adults’ perspectives of the helpful aspects of SFBT, but did not attempt to understand their experience of attending SFBT and change. Whilst some research has attempted to understand adult’s experiences of SFBT, no research to date has attempted to elicit children or young people’s perspectives.

1.10 Eliciting children and adolescents’ views of therapy

In the past, researchers have shied away from conducting research with young people and instead have asked adults (e.g. parents or carers) to be the informants about young people’s experiences. Researchers had doubted young people’s verbal skills, conceptual abilities, recall and ability to convey experiences through narratives (Docherty & Sandelowski, 1999). However, a shift within research generally resulted in an acknowledgement that children and adolescents must be the best source of information about issues that are important to them (Scott, 1996; cited in Morrow & Richards, 1996). Furthermore, in recent years young people have been included as research participants ‘in their own right’ (e.g. Roose & John, 2003; Stith et al. 1996; Strickland-Clark et al. 2000) and have been valued in their contribution and ability to articulate and express themselves.
There is currently no research which has specifically asked young people about their experiences of attending SFBT. There are only three studies which have attempted to elicit young people’s views of family therapy (i.e. Stith et al. 1996; Strickland-Clark et al. 2000; Lobatto, 2002), and extensive literature searches revealed no further studies of young people’s experiences of other types of psychotherapy.

Stith et al. (1996) interviewed 16 children aged between five and 13, who had participated in family therapy for a minimum of four sessions. Out of the 16 children interviewed, 10 were identified as the index client with the majority experiencing difficulties expressing or managing anger. They used multiple sources of data by also interviewing the parent or an older sibling about their perspective on the young person’s experience. The themes to emerge fell into four categories; reactions to the process of videotaping and live supervision; how they understand why they attend therapy; how they understand what happens in therapy; and what they say changed both in the therapy process and at home. In particular, Stith et al. (1996) found that all of the young people indicated a desire to be included in family therapy and found action-orientated approaches more involving than talk alone. They suggest that future qualitative research into children’s experiences of various types of family therapy would be beneficial, and might indicate whether certain approaches are more appropriate for children.

Strickland-Clark et al. (2000) conducted a qualitative study to explore the nature of children and adolescents’ experiences of being in family therapy. They interviewed five young people aged between 11 and 17 who were identified as the index client. The young person was interviewed individually using a semi-structured interview format immediately after a session of therapy. The emerging themes were clustered into six broad themes: the importance of being heard; coping with challenges presented during therapy; the therapy process serving as a space where painful memories were brought up; concern about reactions from other family members; concern about the consequences of speaking out during the session; and the need for support in the sessions. They concluded that the young people interviewed were thoughtful and articulate in their answers and
demonstrated a capacity to reflect on their experiences in a meaningful way. They also suggested that research which aims to elicit children’s views of therapy can empower children and lead to more child-centred service provision.

Lobatto (2002) interviewed six children aged between 8 and 12 about their experiences of family therapy. She found that children struggle to know the rules of therapy; viewed themselves as the problem; felt discomfort at times during the process which they managed in a number of ways; and talked of their experiences of negotiating a position within the therapeutic and family system. Lobatto (2002) suggested that the findings support Stith et al. (1996) in that young people were keen to be included in family therapy but preferred for the focus to not be solely on them. Furthermore, both Strickland-Clark et al. (2000) and Lobatto (2002) found that young people experience family therapy as both including and excluding them at times. When individuals felt heard and validated by the therapist the working alliance was perceived as strong (Lobatto, 2002). They suggest that therapists need to think about how children are included in therapy and how to create an environment in which young people can be included and given permission to express their views. Furthermore, Lobatto (2002) suggests that approaches that position the child as an expert in solving their problems may be beneficial in meeting these challenges.

The qualitative studies conducted to date on children’s experiences of family therapy indicate that young people are able to articulate and reflect on their experiences. They found the open-ended nature of the interview process was most appropriate for older and more articulate children (Stith et al. 2002). All of these researchers highlight the continuing need to explore the nature of young people’s experiences of therapy. The studies to date have explored family therapy in general. Metcalf and Thomas (1994) comment that further research exploring client’s perceptions of SFBT “can be utilized to encourage more effective and meaningful therapy” (pp. 66).
1.11 **Aims and objectives of the study**

The aim of the current study is to explore and understand young people's experiences of being engaged with a SFBT clinic, and the meanings they attribute to this experience. In the wider context, it is important to gain service users perspectives and to incorporate these findings in a meaningful way to improve services. The recent National Service Framework for Children, Young People and Maternity Services, also points to the importance of including children and young people's views (Department of Health, 2004). The information gathered from the young people during this study will directly effect how the therapists involved in this research conduct their clinical practice. Furthermore, as there is very little research into young people's experiences of psychotherapy in general, this research will contribute to growing research in this area and offer information about how to provide effective and meaningful psychological therapies for young people.

In light of the paucity of research where young people's views have been sought I thought a qualitative research method would be appropriate to ensure that young people’s voices were heard. Furthermore, an increasing number of researchers have employed qualitative research methods in this area (e.g. Stith *et al.* 1996; Strickland-Clark *et al.* 2000; Metcalf & Thomas, 1994). Exploring the client’s account of psychotherapy through qualitative research methods enables the researcher to gain a deeper insight into the phenomenon investigated. Quantitative approaches to psychotherapy research tend to be employed when the researcher is interested in measuring how much change or how effective different psychotherapy approaches are for a group of individuals. Qualitative research, on the other hand, aims to “understand and represent the experiences and actions of people as they encounter, engage, and live through situations” (Elliott *et al.* 1999; pp. 216). These methods are most appropriate for answering research questions which focus on the exploration of experiences and the understanding of meaning (Dallos & Vetere, 2005). They are useful when researchers are interested in exploring the meaning that the individual attributes to change rather than measuring this change (Dallos & Vetere, 2005).
I therefore decided that a qualitative method would be the most appropriate method to explore young people’s experiences of SFBT and the meaning of change during this process. The main advantage of using a qualitative methodology for the current research is that the individual’s experience can be studied in depth and their language can be retained. The current research will provide an insight into young people’s experiences in depth and from their personal perspective, and it is also hoped that further hypotheses might be generated that could then be tested through further research.
2. **METHODOLOGY**

2.1 **Choice of qualitative methodology**

A range of qualitative research approaches are available which vary depending upon the epistemological and philosophical assumptions underlying the approach. Interpretative Phenomenological Analysis (IPA) is a qualitative research approach which was developed as a way of exploring in detail participant’s views of the phenomena under investigation (Smith *et al.* 1999). IPA is a relatively new approach that has been readily applied within health psychology research and more recently within clinical psychology. Willig (2001) highlights that IPA is a method which aims to capture the "*quality and texture of individual experience*" (pp. 53). IPA does not focus on whether or not the participant’s accounts are true or false as the interest lies in how people experience the world, and thus IPA is often stated as adopting a relativist ontology (Willig, 2001). IPA does not ascribe to a positivist view that the external world directly determines our perception of it, but instead recognises that the meanings that people ascribe to events are influenced by social interactions and processes (Willig, 2001). The approach is phenomenological as the focus is on the individual’s perceptions and descriptions of the experience rather than attempting to produce objective statements about the subject (Smith & Osborn, 2003). The interpretative component acknowledges that whilst one may aim to gain an ‘insider’s perspective’ the researcher’s understanding of participants thoughts is necessarily influenced by their own ways of thinking, assumptions and conceptions (Smith *et al.* 1999). Rather than viewing this as a problem that needs to be eradicated, researchers employing IPA see this as a necessary precondition for making sense of another person’s experience (Willig, 2001). In essence, the IPA researcher is interested in how people make sense of an experience and endeavours to seek this information via the researcher attempting to make sense of the participants making sense of a particular experience within their world (Smith & Osborn, 2003). Therefore, the philosophical position in IPA is that you cannot represent the ‘other’ completely, but instead can aim to get as close as possible to their meanings. The main focus is on the
meaning that particular events, experiences or states hold for the participants (Smith & Osborn, 2003).

The researcher is seen to play an active role in making sense of the data and engages in a process of self-reflexivity to explore how their own personal beliefs and motivations may be influencing or biasing the research process (Dallos & Vetere, 2005). Thematic analysis also seeks to identify themes and cluster these in meaningful ways, but it does not consider the impact of the researcher's own beliefs or place a focus on the importance of reflexivity (Dallos & Vetere, 2005). I therefore chose IPA over thematic analysis as I felt that it would be important to consider my own beliefs and influences on the research process and emerging interpretations.

The objective of the current research is to explore young people's perceptions of their experience of SFBT. I sought to understand the experience of attending SFBT, through the eye of the individual, rather than attempting to produce universal laws which assume that a 'truth' exists. I was interested in how young people make sense of their experience of SFBT and any change that occurred, and therefore thought that IPA would be an appropriate approach. I hoped to gain access to their thoughts and beliefs about the process of SFBT through semi-structured interviews, which enable young people to have the opportunity to guide the conversation and explore areas of interest to them.

In the current study the phenomena under investigation is young people's experience of attending SFBT. Within IPA, there is an assumed link between what people say, their thinking, and their emotional states (Smith & Osborn, 2003). Therefore what the young people say during the interview is assumed to provide insight into their thoughts, beliefs and emotions. When employing IPA, the researcher is interested in the individual's subjective experience of their world, rather than the objective nature of the world, and acknowledges that individuals can experience the same objective conditions in different ways, as a result of the meanings they attribute to the event (Willig, 2001). This therefore
fits well with the constructivist foundation of SFBT which acknowledges that people make sense of the world through their experiences and interactions.

A limitation of employing IPA to the analysis of interviews is the assumption that language provides access to the thoughts and beliefs that the individual holds. In light of the focus within SFBT on conversation and language, it could be suggested that an approach that focuses on the importance of language in constructing reality, such as discourse analysis, might be appropriate. However, IPA was chosen as it is more appropriate when the research question is focused on ‘understanding’ individuals’ experiences (Shaw, 2001), and what the participant thinks or believes about the area studied (Smith et al. 1999).

Grounded Theory (GT) analysis (Glaser & Strauss, (1967) and Henwood & Pidgeon (1992); cited in Barker et al. 2002), a more mature qualitative research methodology, would have also been an appropriate methodology for the current research. Different versions of grounded theory have been developed which vary in the extent to which the researchers involvement and subjectivity is incorporated. The subjectivist version of GT holds many similarities with IPA (Willig, 2001). Considerable discussion exists about the differences between IPA and GT and the reasons for choosing one approach over the other. It has been argued however, that IPA is a “specifically psychological research method” (Willig, 2001; pp. 69), whereas GT is more appropriate when researchers are aiming to explore social processes. In addition, in GT the researcher engages in a process of theoretical sampling, whereby the researcher deliberately seeks out particular participants to test out the emerging theory and aims to reach a position whereby little new information is emerging, known as theoretical saturation (Barker et al. 2002). I was aware that it would be difficult to engage in a process of theoretical sampling due to the small numbers of potential participants available for the current study and therefore decided that IPA would be more appropriate than GT in this instance.
I also selected IPA as I was interested in representing the shared experiences of a small number of individuals. A series of individual case studies, or narrative analysis, which focuses more on the individual accounts rather than shared theme development, could have been chosen as a way of presenting a deeper understanding of a few individuals or exploration of an individuals' construction of self. However, I was aware that anonymity of participants would not be possible if a narrative analysis or case study approach was chosen, and thought this might inhibit young people from talking freely about their experiences. Furthermore, I was keen to obtain a generalised understanding (Willig, 2001) of how young people experience and understand the process of attending SFBT, and wanted to explore the shared experiences of the young people whilst also highlighting what was distinct for certain individuals where this felt appropriate. Incorporating these considerations, I decided that IPA would be the most appropriate methodology to address the research aims.

2.2 Ethical issues

In deciding to conduct the current research with young people, a number of ethical and methodological issues had to be considered.

2.2.1 The research relationship

One of the main concerns when engaging young people in the current research was the impact of the power differential between myself and the participants. How I was perceived by the participants, as a result of the age gap between us and my professional status, was likely to influence the interview process. Stith et al. (1996) state that an "unequal status is a given" (p. 72), as a result of the culturally held norms about the status of adults and children and these relationships. I was also aware of the possibility of being viewed as an ‘expert’ and that the young people may answer in a way that they think is expected (Mahon et al. 1996). As guided by Stith et al. (1996), in the current study the interview began with a chat about the young person’s hobbies, family and interests to
develop rapport and place the child at ease. I also emphasised that I was interested in their personal views and maintained a stance of curiosity. I described how the information gathered would be fed-back to help services improve therapy for future individuals and help the team think about young people’s views. In this sense it was hoped that the young person would see themselves as the expert on their experiences (Stith et al. 1996). Furthermore, as a trainee clinical psychologist I have substantial experience in interviewing young people and drew upon my skills as a practitioner in both helping the young person to feel at ease and following the child’s lead during the interview. The interview was set up as an informal conversation and the semi-structured interview schedule meant that the young people could raise any topics of importance to them (Mayall, 2000). The semi-structured interview schedule was used as a guide and open-ended questions were used to elicit spontaneous narratives (Docherty & Sandelowski, 1999). Care was taken to avoid leading questions which would suggest a ‘correct’ answer to the young person and influence their responses (Dockrell et al. 2000).

2.2.2 Informed consent and assent

Young people develop the capacity to make informed decisions at varying rates (Central office of Research Ethics Committee, 2003). In line with the Central office of Research Ethics Committee (2003) guidelines and legal requirements, individuals over the age of 16 were considered able to make an informed decision about participating in research. In the case of individuals under the age of 16, parental consent was sought. It is appropriate and respectful however to gain informed assent from the young person. Furthermore, for a research study of this design whereby the young person’s detailed descriptions are elicited, it is important that the young person is enthusiastic and keen to take part (Ireland & Holloway, 1996).

2.2.3 Confidentiality and anonymity

Maintaining participant anonymity was especially important to ensure that the young people could feel free to talk openly and honestly about their experiences. The transcripts were therefore fully anonymised and any potentially identifiable details were removed.
from quotes used within the results section. The issue of anonymity of participants was particularly difficult within the current study. Due to the small number of participants and the individuality of their difficulties and accounts, a large amount of information has been omitted to ensure anonymity.

2.3 Participants

2.3.1 Criteria for participation
All young people aged 11-18 who were attending or had recently (within 2 months) completed SFBT, in one clinic, were potential participants. Individuals who did not return following an initial appointment were not included in the research as it was decided that they would not have had the time to fully experience the therapeutic approach. Asides from young people with no verbal communication, there was no further exclusion criteria.

2.3.2 Situating the sample
Elliott et al. (1999) highlight the importance in qualitative research of providing the reader with information about the participants’ life circumstances to assist the reader in determining the population to which the results may be of relevance. A dilemma within the current research was ensuring that participant’s anonymity is maintained whilst providing the reader with sufficient information to understand the contexts of these individuals. Participant’s anonymity would have been breached by detailed discussion of each participant individually as the individual’s therapists would be able to identify participants from this information by a process of ‘guess work’. I have therefore decided to present brief individual information about each of the participants and further more detailed information at a group rather than individual level.

2.3.3 Participant characteristics
The young people were aged between 11 and 17 at the time of interviewing (one 11 year-old, two 13 year-olds, two 14 year-olds, two 15 year-olds, and one 17 year old). All of
the participants were of White British ethnicity and came from a mixture of social backgrounds. Individual’s presenting difficulties varied, including obsessive compulsive disorder, anxiety, depression, enuresis, anger problems, food selectivity, sleep problems, behavioural difficulties and school anxiety. Individuals often had more than one presenting need. With the exception of one individual, all of the participants were in full time education. One individual was attending a school for children with mild to moderate learning difficulties whilst one individual was being home tutored. Five of the young people had met with other professionals within the child and family service prior to attending the SFBT clinic. Seven out of the eight participants had attended between 3 and 6 sessions. These sessions most often occurred on a monthly basis. One individual had attended 23 appointments over a period of 2 years with a gap of 3 months. The most recent involvement had involved 2 sessions over a 3 month period. Table 1 indicates the young people’s therapy status at the time of the interview.

Table 1: Participant Details

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Pseudonym</th>
<th>Therapy Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chris</td>
<td>Discharged</td>
</tr>
<tr>
<td>2</td>
<td>Alice</td>
<td>Active</td>
</tr>
<tr>
<td>3</td>
<td>Sarah</td>
<td>Discharged</td>
</tr>
<tr>
<td>4</td>
<td>Ben</td>
<td>Active</td>
</tr>
<tr>
<td>5</td>
<td>James</td>
<td>Review</td>
</tr>
<tr>
<td>6</td>
<td>John</td>
<td>Active</td>
</tr>
<tr>
<td>7</td>
<td>Mike</td>
<td>Discharged</td>
</tr>
<tr>
<td>8</td>
<td>Mary</td>
<td>Review</td>
</tr>
</tbody>
</table>

2.4 The setting

The study was carried out at a SFBT Clinic (hereafter referred to as the Clinic) in a Child and Adolescent Mental Health Service in the South of England. The Clinic was run by
two Clinical Psychologists who had each attended courses at the Brief Therapy Practice which is Europe's largest provider of solution focused training. They have been working together for five years.

Individuals attending the clinic are taken from the child and family service generic waiting list and therefore typical of the clients seen by psychologists within child and family services. On some occasions specific referrals are made to the clinic, such as when individuals have been seen by another professional and requested an alternative therapy, or where progress has not been made. Generally, one of the psychologists leads the work with the family/individual, whilst another observes from behind a one-way screen. The therapists often take a break part way through the session and discuss messages to feedback. However, for three of the participants in the current research, this setup was altered. For one participant the observing therapist remained in the room, and for a second participant only one therapist was involved. For a third participant, the sessions initially followed the format described above and then evolved so that the participant met individually with one therapist whilst the other met with his mother, before coming together again as a whole group. Whilst the set up varied for these individuals, for all participants the therapy was based on the assumptions and techniques of SFBT outlined in the introduction section. In line with the assumptions of SFBT, each session is treated as potentially the last session and the referred individual chooses whether and when they would like to come back. Therefore, the length of time between sessions and the number of sessions completed varies according to the needs of the individual.

2.5 Procedure

2.5.1 Recruitment process

1. Ethical approval was obtained from West Sussex Health and Social Care NHS Ethics Committee (Appendix 2) and The University Ethics Committee (Appendix
3). Approval was also obtained from West Sussex Research and Development Department (Appendix 4).

2. Participants were identified by the Clinical Psychologists running the Clinic from their current caseloads between September 2005 and May 2006. The therapist initially mentioned the research to the young person (and for those aged under 16 their parent/person with parental responsibility) and asked them if they would like to meet with the researcher to find out more about the research.

3. If the young person agreed, I then arranged a meeting to discuss the research. The person with parental responsibility was included in the discussion for those under the age of 16, and at the young person’s discretion for those over 16. I went through the Participant Information Sheet and answered any questions that the young person or their family had. Three versions of the Participant Information Sheet were produced, one for young people aged between 11 ands 15 (Appendix 5), one for those over 16 (Appendix 6), and one for the parents (Appendix 7). The young person was given the Participant Information Sheet to keep, and given an opt-in reply slip which they were asked to return in a pre-paid envelope within 2 weeks if they would like to participate in the research. All of the participants in the current study agreed to participate in the initial meeting and did not want to take the information away to think about it.

4. Fifteen individuals were approached in total. Five declined at the initial stage when asked if they would like to meet to find out more about the research. Two individuals came to the meeting to hear about the research, but did not return the opt-in reply slips. Eight individuals agreed to take part in the research.

5. The gaining of informed consent varied for those under 16 and those over the age of 16. Written consent (Appendix 8) was obtained from the person with parental responsibility and written assent (Appendix 9) for young people under 16. Individuals 16 years and older were able to provide their own informed consent and again written consent was obtained (Appendix 8). Consent was obtained to audio tape record the interview and to access individual’s case notes for demographic details.
2.5.2 Development of interview schedule

1. The semi-structured interview was developed in conjunction with the clinical psychologists who run the SFBT clinic and with a research tutor on the doctorate in clinical psychology course at the University of Surrey. I was also guided by previous research into adult’s perceptions of SFBT (Metcalf & Thomas, 1994; Joel & Nelson, 2004) and research involving children and adolescents views of family therapy (Strickland-Clark et al. 2000; Stith et al. 1996; Lobatto, 2002). However, I was keen to keep the interview schedule as open as possible and this was intended as a guide to facilitate the young people in describing their experience. The topic guide can be found in Appendix 10.

2. The semi-structured format allowed me the flexibility to change the language of the questions in line with the young person’s ability. The interview schedule began with a short “getting to know you” chat to help the young person feel at ease. This settling-in phase also gave me an opportunity to consider the young person’s communication style and adjust my language and pace accordingly (Cameron, 2005).

2.5.3 Interview process

1. Once consent had been gained, a date and time to complete the research interview was agreed.

2. The interviews were conducted in the clinic where the young people attended SFBT. The young person was asked if they would be happy to be interviewed on their own or if they would like a parent or friend to come with them. Six participants were interviewed alone and two, Mike and Chris, decided to have a parent (mother) present.

3. Prior to commencing the interview I briefly went over the information provided in the Participant Information Sheet and reminded the young person that we could stop the interview at any point if they wanted to. As a precaution, in the unlikely event that the young person found the research distressing, the clinical
psychologist who had worked with the child was available during the period of the interview to talk with them if necessary. However, none of the young people showed or reported any distress during the interviews.

4. The semi-structured interviews lasted between 20 and 70 minutes. Once the interview had concluded, the participants were offered the opportunity of receiving feedback about the research through an informal meeting or a written summary. Six individuals accepted the offer of receiving a written summary, and one individual opted to meet with me to discuss the results.

5. Following each interview I transcribed the audio-tapes verbatim. I have included an anonymised section of one participant’s transcript in Appendix 11. I have not included a whole transcript for one participant in order to maintain participants’ anonymity.

2.6 Qualitative analysis

An idiographic approach to analysis was adopted where the focus was on individual accounts initially, progressing towards a more general categorisation of shared themes across the accounts (Smith et al. 1999). There are no prescriptive rules within IPA in relation to the analysis of the data but I was guided by the step-by-step approaches to IPA set out in Willig (2001) and Smith and Osborn (2003). The analysis involved a number of different stages:

1. The most in-depth interview was chosen initially for full analysis. The transcript was read and re-read a number of times, noting in the left-hand margin any thoughts or observations in response to the text including associations, attempts to summarise or paraphrase the information, and interesting uses of language.

2. I then re-read the transcript and in the right hand column noting any themes that were emerging. This process was completed for the entire transcript and an example of this analysis is available in Appendix 12.

3. I then listed the emerging themes in chronological order onto a piece of paper, looked at how these themes were connected and clustered themes together. I then
produced a list of the clusters and where possible developed a label for these themes. The list of emerging themes for this first participant is available in Appendix 13.

4. In order to capture the diversity of individual’s experiences, I conducted this same detailed analytic process with another transcript and again developed a list of the emerging themes (see Appendix 14).

5. I then read each of the remaining transcripts with these master lists of themes in mind. During these readings I looked for similarities and differences within themes as well as noting new themes that emerged. If new themes emerged in later transcripts, I returned to earlier transcripts to see if there was evidence of that theme present. This involved continued re-reading of the transcripts whereby new themes could be added, amalgamated or further expanded.

6. A final list of emerging master themes, super-ordinate categories and sub-themes is available in Appendix 15. A table containing quotes from the participants is available in Appendix 16.

2.7 Research quality checks

The detailed description of the analytic process provided above, and examples of this in Appendices 11-16, provides the reader with some insight into how I moved from the raw data to the findings and interpretations presented in the results and discussion section. This is often referred to as an ‘audit trail’ and is one way of approaching validity in qualitative studies. Elliott et al. (1999) developed some guidelines to assist with evaluating the quality of qualitative research. Two of these standards have been integrated within the methodology and results section. Firstly I have attempted to situate the sample by providing some anonymised information about the research participants in the section above. Secondly, in the results section I have provided examples of the data through presentation of participants’ quotes in an attempt to ground the data in examples. I have also provided a table in Appendix 16 which demonstrates how the themes are grounded in each participant’s data. There are two additional standards that require
further elaboration for the present research; providing credibility checks and owning one’s perspective.

2.7.1 Credibility checks

I have made attempts to check the credibility of the emerging analysis at various stages. I have met with my research supervisor throughout, and she has checked the development of the analysis and read a number of the transcripts. Initially, my research supervisor read the first transcript and conducted her own independent analysis. We met to discuss our emerging themes and considered any differences of opinions as a way of enriching the analytic process. This process of discussing the independent analysis also provided an opportunity for my research supervisor to comment on whether my emerging analysis and interpretations ‘made sense’ and adjustments were made if appropriate. This process was conducted with two interviews that were quite different. I also met with my research supervisor regularly at the point of clustering the emerging themes. Following the development of the master list of themes, my research supervisor read another transcript with the master list of emerging themes and checked that the themes were grounded in the data.

I also met with a group of seven fellow trainee clinical psychologists also undertaking research using interpretative qualitative methodologies. The group read part of one transcript and looked for emerging themes. We then discussed their interpretations and considered how well this fitted with my own analysis. I compared the themes generated by the group with my own and this process resulted in refinement of the theme clusters as well as ensuring that any idiosyncratic interpretations were removed. In the final phase of the analytic process, I collated a random selection of quotes from the range of participants’ transcripts and individuals within the trainee group matched the quotes to the list of Master Themes and Super-ordinate categories. I discussed the allocation of quotes to particular themes with individuals and in the majority of cases individuals either
selected the category consistent with my own analysis or upon discussion were able to see and understand the interpretation.

One of the dilemmas that I faced in the current study was determining the appropriateness of gaining respondent validation. This has historically been considered to be the most appropriate way of checking the credibility of the researcher’s interpretation, but a number of limitations exist with this method (Mays & Pope, 2000). Some debate currently exists as to the appropriateness of respondent validation considering the power differential between the researcher and the participants (e.g. Henwood & Pigeon, 1992). Researchers have questioned whether participants would feel able to contradict the researcher’s interpretations as a result of the power dynamics with the researcher and participant relationship. In the current study, this was amplified as the participants were children and adolescents. Furthermore, I thought that some of the young people may struggle to understand the interpretative account and therefore an alternative modified version would need to be created. This would then mean that the young people were not commenting on the version that would be included in final publications or the thesis. In addition to this, Mays & Pope (2000) highlight that researchers’ and participants’ aims differ in that researchers are aiming to provide more of an overview, and within IPA shared themes, where as participants often have more individual concerns. However, during the interviews I made attempts to check out my understanding of the young people’s experiences through summarising and seeking clarification.

I therefore decided that I would not attempt to formally gain respondent validation. However, once the analysis had been completed a summary of the findings was produced for the young people who took part in the research. This included a brief summary of each of the emerging themes and the conclusions and recommendations for the service. The covering letter provided young people with a contact telephone number and invited participants to contact the researcher if they had any questions or wanted to comment on the results. To date, no young people have commented on the results. The summary was sent out to those participants who requested feedback and a copy is available in Appendix
17. One individual requested to receive feedback in person and a meeting has been scheduled. This may provide an opportunity to gain one individual’s comments on the results. Consideration of how young people’s comments could be sought in the future is included in section 4.6 (page 238).

2.7.2 Owning one’s perspective

Within IPA the researcher’s position and beliefs are acknowledged as integral to the interpretative process. The researcher must engage in a process of self-reflexivity throughout the research process to explore their own personal beliefs and motivations which may bias the analysis and influence the emerging themes (Dallos & Vetere, 2005). I used a variety of methods to facilitate this process of self-reflexivity, including setting up an interview with a colleague to explore my motivation behind conducting the research and any areas of potential bias, and keeping a reflective diary. The following provides the reader with an account of my original position at the outset of this research.

I was personally motivated to conduct this research as I was struck by how, within mental health services, young people’s views have rarely been sought, and I was keen to contribute to research that addresses this imbalance. I am aware that in some sense I perceived myself as ‘giving young people a voice’ and wondered whether they might have experiences of being not heard or respected by services.

It is important to reflect on my current position as a trainee clinical psychologist with an interest in specialising within child and adolescent mental health upon qualification. I completed a core and specialist placement during training within the child and family service that served as the setting for the research, and therefore I have a personal connection with the service that the young people attend and the psychologists who run the clinic. In addition to this, over the course of training I have become interested in psychological approaches that focus on the client’s resources and are not based on pathological views of mental health. This has included an interest in both SFBT and
narrative therapy approaches, and I was aware that I held assumptions that SFBT and other non-pathological approaches would be experienced positively by young people. I had attended a SFBT four day training course prior to clinical training and then observed and practised within this orientation during my child and family core placement. On the other hand, as a trainee clinical psychologist I had opportunities to practise within a variety of therapeutic orientations and therefore do not hold a strong allegiance to SFBT. In fact, I personally had concerns that the approach was quite rigid and that on some occasions people may be seeking therapy to gain understanding and feel put off by the goal focused nature of SFBT. However, I also wondered whether SFBT may be better suited to children who may be less interested in seeking to understand the cause of problems and more keen to find solutions. This stemmed from my own interests as an adult in understanding the causes of problems, and from observing within my clinical work that often its children’s parents that are interested in understanding the problems and that young people seem to become more engaged in therapy once the focus is on the development of solutions. Furthermore, my developing interest in narrative therapy ideas meant that I also held some reservations about the SFBT approach in terms of the limited exploration or deconstruction of individual’s difficulties and beliefs/values that may be important. Through observing a variety of different therapeutic approaches I observed that young people seemed to find SFBT uplifting and was interested therefore in further exploring their perceptions and experiences. Also as an adult who has an interest in specialising within child and adolescent mental health upon qualification, I was aware that I hold assumptions about the potential benefits of therapy. I was therefore careful to ensure that I would notice and attend to young people's experiences that did not support these assumptions.

I therefore held a number of beliefs about what might be meaningful to young people about the SFBT experience. In particular, I identified that I thought that being helped to find solutions to problems in their lives would leave young people feeling in control of their lives and their psychological health. I also held an expectation that individuals would compare SFBT favourably with previous experiences that may have been based on
pathological models of understanding. I also held the assumption that the SFBT approach would utilise hope and that young people would feel more positive about themselves and their future after meeting with the therapist. However, I also wondered whether some young people would feel frustrated with the focus on solutions and want to discuss and understand the origins of their problems in more detail. I also became aware of a tension between my position as a researcher and a past and possible future colleague of the psychologists that ran the clinic. I was aware that this might lead me to search out favourable evaluations of the clinic and in some ways miss the young people’s experiences that were not positive. I have tried to control for these assumptions by actively listening to the young people and being aware of this during the interview and interpretative phase of analysis. I feel that being aware of these biases from the outset has enabled me to monitor the influence of this throughout the analytic process.
3. RESULTS AND DISCUSSION

3.1 Summary of Themes

The following clusters of themes presented in Table 2 emerged during the analysis.

Table 2: Master themes and Super-ordinate categories

<table>
<thead>
<tr>
<th>Master Theme</th>
<th>Super-ordinate Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Entrance to therapy</td>
<td>1. Reason for seeking therapy</td>
</tr>
<tr>
<td>2. Views pre-therapy</td>
<td>2. Views pre-therapy</td>
</tr>
<tr>
<td>2. Therapist relationship factors</td>
<td>1. Therapist’s role</td>
</tr>
<tr>
<td>2. Therapist’s personality and attitudes</td>
<td>2. Therapist’s personality and attitudes</td>
</tr>
<tr>
<td>3. Therapist’s position</td>
<td>3. Therapist’s position</td>
</tr>
<tr>
<td>3. Elements of SFBT that supported the change process</td>
<td>1. Getting to know me (problem free talk)</td>
</tr>
<tr>
<td></td>
<td>2. Therapy conversations</td>
</tr>
<tr>
<td></td>
<td>3. Usefulness of scaling</td>
</tr>
<tr>
<td></td>
<td>4. Importance of praise</td>
</tr>
<tr>
<td>4. Facilitative factors in the process of change</td>
<td>1. Client motivation</td>
</tr>
<tr>
<td></td>
<td>2. Approach to change</td>
</tr>
<tr>
<td></td>
<td>3. Importance of significant others</td>
</tr>
<tr>
<td></td>
<td>4. Fortuitous events</td>
</tr>
<tr>
<td>5. Reflections on therapy</td>
<td>1. Range of improvements</td>
</tr>
<tr>
<td></td>
<td>2. Reflections on the therapeutic experience</td>
</tr>
<tr>
<td>6. Control</td>
<td>1. Control over therapy</td>
</tr>
<tr>
<td></td>
<td>2. Control over change</td>
</tr>
</tbody>
</table>

These themes will be discussed in turn, in more detail, incorporating quotes\(^2\) from participants to highlight the range of experiences and show the reader how the themes are grounded within the data. Where appropriate, I have integrated psychological theory and

\(^2\) Where quotes are included, information within brackets [ ] is included to clarify what is being said. Ellipsis points (…) are used when parts of the quote have been omitted.
previous research into this discussion to demonstrate how the current findings are situated within this context (Yardley, 2000).

3.2 Master Theme 1: Entrance to therapy

3.2.1 Reason for seeking therapy

Children and adolescents rarely initiate referrals to services or identify themselves as needing a service (Kazdin, 2003). For the majority of individuals in this study the contact with the service was initiated by a parent or another professional. However, all of the young people in this study appeared to have a clear perception of why they attended the clinic. They experienced therapy as a place where problems or difficulties could be overcome with the support of another person. Stith et al. (1996) also found that young people viewed overcoming a problem as the main focus. Lobatto (2002) found that children attending family therapy took ownership of the problem, and this seemed to mean that the problem was something within them. The young people in the current study also took ownership of their problems and described these in the past tense:

James: "just to sort out problems that were, that I was facing"

Chris: "I was very stressy"

Two female participants also understood therapy to be an opportunity to gain insight and understanding into their problems. This was epitomised by Mary when she said:

Mary: "she'd maybe be able to give me some solutions ... just be there as a sort of support ... give me an insight"

Chris and Alice indicated the significance of asking for help themselves and were keen to be able to talk with professionals and overcome their problems:

Chris: "I asked for it myself and that's good for me"

Similarly, Sarah described the importance of being asked by other professionals personally if she would like to meet with someone rather than this being decided for her
by her mother. Being in control of the decision of whether to come to therapy was therefore significant for these individuals:

Sarah: “they asked me whether I wanted to go and see her, and not mum ... because if they asked mum whether she wanted me to go and see her it would have been a bit annoying”.

3.2.2 Views pre-therapy

The majority of the young people found attending the first therapy appointment anxiety provoking and were apprehensive about what would happen. Mike, James and Sarah, who had previous experience within the child and family service, did not experience this anticipatory anxiety. The other young people described feeling “worried”, “confused” and “nervous”. It seems that the anxiety stemmed around not knowing what would happen “whether they were going to like take my blood samples” (Ben) and not knowing what the therapist would be like:

Mary: “it was quite nerve wrecking because I didn’t know her, she didn’t know me and she didn’t really know much about me or anything about it”

The anticipatory anxiety for some individuals also included worries about how the therapist would think of or respond to them:

Alice: “I was scared Psychologist 2 would think bad of me”

Alice experienced conflicting emotions about attending as she was nervous “partly I didn’t want to come ...” yet keen to meet with someone to be able to talk about her problems:

Alice: “It felt quite good actually, because I was so happy to be able to talk to somebody”

Whilst Alice seemed to have ambivalent feelings about coming to the clinic, she seemed hopeful regarding the possibility of change through attending therapy. Expectancy and hope have been found to be important factors for successful change (Murphy, 1999). Individuals often seek psychological help at a time when they feel their own attempts to overcome a problem have failed and therefore feel powerless to change (Frank, 1973; cited in Snyder et al. 1999). Mary expressed her feeling of hopelessness at the outset of
the therapy stating that she “couldn’t see it sort of getting better”. She was anticipating that the therapist would be the agent of change as she expressed “it was very much sort of in her [the therapist’s] hands”.

The individuals’ experiences during the first session appeared to invalidate any negative expectations they held:

Mike: “It was just like more open than I thought it would be ...”

Ben: “it’s not like a blood sample ... [or] loads of mental tests on you, it’s just a chat really”

All of the individuals indicated that their anxiety was substantially reduced after meeting the therapist in the first appointment. This appeared to be facilitated by the emphasis within the first session on ‘getting to know me’ achieved through the SFBT technique of ‘problem free talk’ and described in more detail in Master Theme 3.

3.3 Master Theme 2: Therapist relationship factors

All of the young people perceived the therapist and the therapeutic relationship to be an important aspect of their experience, which is in line with previous research into adult client’s perceptions psychotherapy (e.g. Metcalf et al. 1996). The young people’s descriptions indicated that they experienced a therapeutic relationship with the therapist and understood this to be important in enabling them to use the sessions effectively. They held clear ideas about the therapist’s role, the importance of the therapist’s personality and attitude, and the position of the therapist as an experienced ‘safe outsider’. Lambert (1992/2003) reported that relationship factors account for 30% of improvement in psychotherapy regardless of the model of therapy. This finding is also consistent with previous research into children and adolescents’ experiences of attending family therapy whereby the personal characteristics of the therapist were viewed as important by both young people and their parents (Stith et al. 1996).
3.3.1 Therapist’s role

The young people experienced the therapist as making suggestions, providing advice or coming up with ideas for them to try. There was evidence throughout that the young people valued the therapist’s suggestions:

**Mary:** “*she was talking through my options...[which] sets where you’re going a little bit and you know what you’re working towards in the future*”.

**Ben:** “*Psychologist 2, who spoke to her, [mum] at the end of the session just saying, I don’t think it’s a good idea pressuring him... if he’s not motivated*”

Client’s perception of therapists as guiding them was also clear in the research conducted with adult clients of SFBT by Metcalf and Thomas (1994). In the current study this appeared to be valued by the clients and seen to be an important aspect of the therapeutic experience. The young people experienced the therapist as taking an active role, which is discussed in more detail in the Master Theme ‘Control’. The young people also perceived the therapist as actively listening to them and this was understood by some to be a crucial and important condition:

**Chris:** “*The most helpfulllest thing she does is listen*”

3.3.2 Therapist’s personality and attitudes

A lot of the young people described how the therapist’s personality and attitude were important in enabling them to develop a working relationship. This spanned many of the known facilitative therapist factors including therapist warmth, empathy, understanding, un-conditional positive regard and genuineness (Rogers, 1957; cited in Bachelor & Horvath, 1999):

**Chris:** “*she’s a nice person...she was understanding...she wanted to help*”

**Ben:** “*chatty, friendly...relaxed*”

**Alice:** “*treating me in a way as a friend would, and it really allowed me to sort of feel that I could trust her and really sort of open up*”
Chris, Alice and James further articulated that they were not viewed as being ‘bad’ because of their difficulties:

_Chris:_ “we ain’t bad people, it’s cause some people think we’re just little like brats cause we just get up to mischief but we don’t...because they know that we ain’t just like that, we’re actually people who are nice who just have difficulty”

Furthermore, for Ben the therapist’s personality impacted upon the therapeutic relationship and he understood this to be important in motivating him:

_Ben:_ “if they’re nice people, you feel motivated, because you want to umm you don’t want to let them down”

Chris described how he experienced the therapist as having belief in him, and his ability to change:

_Chris:_ “belief that’s been one of the most helpfullest things because she believed in me”

A powerful message was being communicated that the therapist believed in the young person. This may evolve from the assumption in SFBT that clients hold the ‘keys to their solutions’ and that change is always present (de Shazer, 1985; cited in Stalker _et al._ 1999).

### 3.3.3 Therapist’s position

Half of the young people experienced the therapist as a safe outsider who was separate to them and could provide an objective position. Sarah found it easier to talk with the therapist as “their job [is] to talk to you”. Alice and John perceived that talking to someone they did not know was helpful in a different way to talking to family or friends:

_Alice:_ “I was so happy to be able to talk to somebody that I didn't really know because I mean I can talk to my friends and my family but there’s only so much I want to tell them and talk to them about”

Mary articulated this further, experiencing the therapist as an objective person who was not emotionally involved:

_Mary:_ “she's not biased, she'll see it sort of, where as your parents get emotionally involved, she's not emotionally involved ... an unblinkered view I suppose really...someone whose objective, which is nice to have”
Ben, Chris and John also understood the therapist to be experienced in working with ‘people like me’ which meant that the therapist could understand them:

**Ben**: “she seems to have a lot of experience with helping people overcome things”

**John**: “speaking about it to someone else who knows what it is, and what I’m going through...helpful”

This also highlights how the young people clearly felt listened to and understood by the therapist. Tallman and Bohart (1999) suggest that a therapist’s ability to exude confidence in their own ability, as well as the clients, contributes to the development of a sense of safety within the relationship. For the young people in this study, the therapists’ experience and personality seemed to contribute to a sense of hope that change would occur. Sarah indicated that following the first appointment she was hopeful that the therapist would be able to help her:

**Sarah**: “that she’d probably be able to help”

### 3.4 Master Theme 3: Elements of SFBT that supported the process of change

This master theme is comprised of sub-themes that emerged from the individuals’ descriptions of aspects of therapy which seemed to map onto specific SFBT techniques. Research into clients’ perceptions of therapy generally reveals that individuals value common rather than specific factors of therapy, whereas therapists and professionals tend to emphasise the techniques and model (e.g. Metcalf *et al.* 1996). However, for the young people in the current study some specific techniques were spontaneously identified as helpful.

#### 3.4.1 Getting to know me

‘Problem free talk’ is a specific SFBT technique that the therapist introduces in the initial session as a way of finding out more about the client’s life aside from the problem (George *et al.* 2002). The aim is to initiate conversations which enable clients to take an
active part in the therapeutic process and for the therapist to ‘connect with the person’, whilst emphasising the person as separate to the problem and eliciting strengths and resources. Five out of the eight young people identified this technique as “getting to know me”. They appeared to experience this as helpful in two main ways. Firstly, some young people found that this helped to reduce their anxiety and enabled them to relax:

Mary: “she put me at my ease and she just asked me about myself and umm my hobbies and stuff like that”

Secondly, there was a sense that this technique facilitated the development of the therapeutic relationship. Many of the young people thought that this helped the therapist to understand them. Mary felt that it was essential for the therapist to know her well and Chris felt that this enabled him to open up and tell her things that he may have withheld otherwise:

Mary: “if they don't get to know you, then I don't think they can help you straight away because they don't know you”

Chris: “it's showing interest in you...I will talk about things more...I'll tell them things I wouldn't normally tell people”

Furthermore, for Ben, problem free talk was also meaningful as this resulted in identification of a personal resource that could be applied to overcoming his current difficulties:

Ben: “they related the courage that I use in [hobby]...”

The therapist’s interest in ‘getting to know’ the young people seemed to communicate to the young people that they were interested in them and valued them as unique individuals. There was also a sense that this reduced the power differential between therapist and client and helped the development of an effective working relationship. This relates to the young people’s experience of being respected and valued by the therapist.

3.4.2 Therapy conversations

A large theme to emerge throughout the young people’s descriptions of their experiences was the importance of the conversations that occurred during SFBT. George et al. (2002)
suggest that the main therapeutic process in SFBT occurs through the therapeutic conversation. Many of the young people echoed this sentiment by commenting that therapy was about talking. For some individuals, the process of talking to someone was viewed as the most important ingredient for change:

John: "me feeling happier is because me speaking about...me speaking about it and everyone speaking to me about it too, us talking about it"

Some of the young people mentioned the importance of being able to talk about their problems. All but one participant experienced SFBT as providing an opportunity to talk about problems. Talking about problems was experienced as being important for a number of different reasons. There was a cathartic element to this for Chris and James:

Chris: "get it off my chest if there's a problem...hear me out to understand me"

James: "relieved...it was good that I could tell someone all of my worries and that"

The young people experienced a chance to talk about and off load worries and problems. There was a sense for Alice that she felt abnormal, as a result of her difficulties, and gained reassurance from the therapist through the process of talking about her problems:

Alice: "somebody else knew how I felt...reassured...normal"

Within SFBT, therapists aim to direct clients away from conversations about problems which they suggest reinforces problem-saturated stories. Throughout the young people’s descriptions of conversations in therapy, they frequently referred to a focus on talking about improvements. In particular there was a sense that they already had the answers to their difficulties and therapy was experienced as focusing on improvements rather than change:

Alice: "concentrating on who I am...but improving things"

They also experienced the therapy conversations as focusing on the exploration of different solutions and then evaluating their effectiveness:

Ben: "did it work for you, um if it didn't have you got any other suggestions for things that might work"
The young people also experienced the therapeutic conversations as having a distinct positive focus:

Mike: “we’d talk about the good points about it”

James perceived this to be a focus on the positives without ignoring “what’s not so good”. This was perceived as making the therapeutic experience less threatening and therefore encouraged him to continue attending:

James: “so I don’t feel put off...so I might say I’m not coming back...they like put it in another way so even if they mean to be negative they make it good”

This re-framing therefore made the therapeutic experience more comfortable for him. The young people seemed to identify a definite focus on improvements and this was experienced positively. Many of the young people described how they were keen to come back for therapy appointments so that they could tell the therapist how much they had achieved:

Ben: “Well I was proud, because I’d tried...”

Alice: “I felt quite excited because um I sort of felt I achieved so much from the first time I came”

It was also clear that the young people experienced SFBT as including a combination of talking which occurs within the sessions and ‘actively doing’ which occurs outside of the sessions. They referred to ideas that they implemented outside of the sessions and they experienced the sessions as a time to talk about and generate solutions whilst the active period between the sessions was the crucial time to try out different ideas.

Whilst most of the young people seemed to appreciate the focus on improvements and positives, Alice appeared to enter therapy with a model of change in mind that viewed problem exploration as important in bringing about understanding and change. Her experience of problem exploration during SFBT diverged from others, as she was frustrated when the therapist directed her away from problem exploration:

Alice: “I got told that um they didn’t need to know about that but I thought that kind of hurt me a little because I felt that umm I came here to talk about my problems so maybe I could sort of discuss it with them...”
It seems that the model of SFBT did not match with her own model of change which prioritised gaining insight and understanding about her difficulties. This also seemed to communicate that the therapist was the expert. However, Alice also seemed to appreciate the focus on solutions, although clearly would have liked more opportunity to explore her difficulties. Piercy et al. (2000) suggest that the focus on solutions, when the client is trying to tell the therapist about difficulties in their lives, can result in the client not feeling heard and sometimes dis-engaging from the therapy.

### 3.4.3 Usefulness of scaling

Scaling is a technique used within SFBT to explore resources, track changes and evaluate progress (George et al. 2002). Mike, Sarah, Ben, James, John and Mary thought scaling was an effective way of monitoring and measuring their progress:

Sarah: “because you can actually look back and see for yourself that you actually went up that much, and see how you’ve progressed”

In addition, Chris, Ben, Sarah and Mary found the process of scaling motivated them to work harder and be able to aspire towards the future:

Chris: “yeah I’m gonna get an 8 and then you work even harder”

Mary: “sometimes it’s really useful as it gives you a goal...something to be working towards...to aspire towards”

For Mike scaling was also a way of indicating that it was time to finish therapy:

Mike: “that’s why we stopped...one side of the scale to the other”.

Scaling therefore seemed to be experienced as a technique which helped the young people to focus on the future and establish realistic goals. It also seemed to underscore a focus on achievements and resolution of their difficulties.

### 3.4.4 Importance of praise

In SFBT the therapist provides the client with constructive feedback about resources, skills, strengths and abilities. The giving of these messages is known within SFBT as
'complimenting'. Chris, Alice, Ben, James, John and Mary seemed to experience this as praise, and indicated that this was an important aspect of therapy. It seemed important that the therapist praised both their achievements and efforts towards their goals:

**John:** "he's trying really hard"

**Chris:** "saying how well I’ve done"

Alice, John, Chris and Mary experienced praise as increasing their self-esteem:

**Chris:** *I like being praised, umm it makes me feel like I’m somebody it does, it just makes me feel like, I'm not just any old kid, I'm someone who's like special and that*"

**John:** "helps me feel good in myself"

Furthermore, the praise was valued by participants as occurring in the absence of negative feedback if things were not progressing:

**John:** "if it's improving then she'll say good, or if it's gone down a bit that's alright"

Chris and Mary both further elaborated and experienced praise as motivating:

**Chris:** "gives you a boost"

The experience of focusing on improvements and the receiving of praise from the therapist seemed to result in young people feeling keen to attend appointments and be able to talk about their achievements. This seemed to generate a position whereby young people could be proud of themselves and their achievements. The clinic was experienced as a place where success was celebrated. This is highlighted through Ben's expression of how other young people might experience SFBT:

**Ben:** "I think they’d feel confident to, and be excited, to tell the people what they’ve achieved and have a sense of proudness, if that’s a word!"

The explicit use of praise within SFBT can be seen as a technique which both reinforces the development of solutions and client effort, but also goes further towards impacting upon individuals’ sense of themselves, self-esteem, motivation and engagement.
3.5 Master Theme 4: Facilitative factors in the process of change

This master theme describes the young people’s perceptions of factors that facilitated the process of change through mobilising pathways towards personal change. These are separated from the factors discussed above as they are not specific to SFBT. This section includes client motivation, the approach to change, the importance of significant others and the impact of events outside of therapy.

3.5.1 Client motivation

The young people seemed to experience their own contribution as central to therapy. Chris, Alice, Ben, John, James and Mary felt that self-motivation was a crucial element of effective therapy and change. In particular, they seemed to understand this to be a necessary pre-requisite for change:

Alice: “somebody that would really like to change their lives...be able to change”

Ben: “I think I definitely needed motivation...a couple of years ago I didn’t have any...but now I do want to change”

Mary: “...because I think that it actually had to come from me to get that to happen”

In particular these individuals indicated that there had been times in the past when they had not been motivated to change and they suggest that the experience would be less useful if the individual was not motivated to change. Furthermore, for two individuals, they experienced the therapeutic arena as motivating also:

Chris: “she [therapist] made me feel it is going to work”

Ben: “you get the motivation from the professionals that I come and see here”

Alice described how outside of therapy she kept a diary of the sessions to help her to remember the information and set her own goals. There was a sense that the young people experienced therapy as “hard work” and that it was important that they were motivated to try new ideas and were open to the therapists suggestions and help. There
was a sense that the young people were committed to bringing about change in their lives. This links in with the young people’s emerging sense of personal agency which is discussed in Theme 6.

3.5.2 Approach to change

The young people experienced SFBT as a realistic, goal directed approach with a focus on trial and error to discover solutions to problems. This included young people’s experience of the importance of setting realistic aims, a realistic pace and realistic expectation for improvements. Chris, Alice, Ben, Sarah, James and Mary all commented on the importance of a realistic approach to change:

Ben: “Yeah, I don’t set like ridiculous...”

James: “good enough...because you can’t expect miracles”

Furthermore, the perceived realistic aims and pace resulted in individuals feeling that they were supported and able to work at their own pace without being pressurised to change too quickly. The young people seemed to appreciate having control over the pace and this was perceived to enhance their chances of succeeding:

Mary: “so I wasn’t just thrown out there”

Chris: “I’ve got enough time to do it, not to feel like I’m being rushed...I’ve got my own space”

In addition to a realistic approach, some of the young people experienced the discovery of solutions as resulting from a process of trial and error:

Alice: “give this a try and if that doesn’t work try another thing”

Ben: “... trying different methods out, yeah that works...”

Chris explained that this helped him to appreciate that there is more than one way to solve a problem:

Chris: “that’s good because it shows me more than one way of trying to sort things out between ourselves”
Mike, Chris, Sarah, Ben, James, Alice and Mary all experienced SFBT as being goal focused. This included setting small goals on a session by session basis and breaking down problems into smaller manageable targets and overcoming them individually:

**James:** “break down all the problems and sort them out one at a time”

**Ben:** “say what my goals are for next time I'm going to see them”

They also perceived this to be helpful in identifying what the future would look like and what they were hoping to achieve:

**Sarah:** “where I wanted to get”

**Mary:** “what do you want to happen to get you up to say if you're on a 6 what do you want to happen to get up to a 7”

The use of goals within SFBT is thought to create the expectation of change for clients (Stalker *et al.* 1999). Chris described this and also seemed to have internalised an expectation of personal success:

**Chris:** “it's not really a target...just you know you're going to do it”

### 3.5.3 Importance of significant others

All individuals except for Alice and Mike experienced the therapist as giving them the choice about who attended the sessions. The majority of the young people in this research experienced significant others from their support network as playing an important role both within the therapy sessions and outside of this setting. They experienced these individuals as providing support in a number of different ways. Chris described how his mother and extended family supported him to make changes during the process of therapy:

**Chris:** “you need some people to be there, to do it with you to help you do it”

He also described how it was important to have his mother present to enable him to feel safe and be able to talk with the therapist:

**Chris:** “I like my mum to be there cause umm, it's just like for me like, I don't like to talk, I have to have my mum there sometimes, I feel it's safe”
Chris went on to describe how as the sessions continued he gained confidence and was able to come to an appointment on his own. John and Mary described how having someone there who knew them was reassuring and John further commented that his mother helped the process by explaining questions from the therapist that he did not understand:

**John:** "it's better having my mum in there really because like it's just I dunno really it's just like having someone you know there, it helps me, and she helps explain some things to me"

Alice, Ben and James described the importance of support from others in the time outside of the therapy sessions. This relates back to the earlier finding that the therapy process is experienced as including both the time in sessions and the time between sessions.

**Alice:** "with my mum, we sort of sit down and really concentrate on what they told me to improve"

**Ben:** "Well my brother's helped a lot...he's quite a motivating person he helps me"

Chris, Sarah, James, Mary, Ben and John all experienced the presence of significant others within sessions as providing an opportunity for alternative perspectives to be expressed and heard:

**Mary:** *bring mum in...so I suppose so that everyone can put their views across really*

It seemed that therapy was a safe place where these alternative perspectives could be voiced and heard, as well as a sense that this did not always occur outside of the therapy sessions. Alice was the only individual who experienced a negative element to the involvement of another person in the therapy sessions, suggesting that she was constrained by this:

**Alice:** "I find that a bit off putting in some ways, my mum being in the room...I feel personally that I would open up more if she wasn't"

Developmentally, as an adolescent, Alice may have been at a time in her life when she was striving for increased independence and control. However, later in the interview Alice reflected on how her relationship with her mother had improved as a result of
attending therapy together. She may therefore have preferred an opportunity to meet with the therapist both alone and with her mother present.

3.5.4 Fortuitous events

Sarah, Ben, Mary, James and Alice all perceived an external event that occurred outside of the therapeutic arena as being important in bringing about changes. These events were significant for different reasons. Alice indicated that an external event resulted in her thinking differently about friendship and her ability to support a friend in a time of need:

Alice: “Well one of my friends’ mum died and um, I really saw how much she needed support and I think that sort of being able to help her...I really sort of realised how things work”

Mary described how one day a “breakthrough” occurred as a result of an external situation and she was able tolerate her anxiety for a longer period of time than before. This resulted in increased hope and faith about her ability to change and get better:

Mary: “I started to get a bit more positive about my treatment and hopeful, and umm I started to look forwards a little bit more and I think things sort of went up from that”.

Ben described how a situation spontaneously occurred outside of the therapy session which resulted in a reappraisal of the meaning of his difficulties:

Ben: “I just thought, it’s not going to kill me and I found it quite nice”

Although these events did not happen as a result of therapy, it is possible that the young people seized the opportunity provided to change their way of doing things, and would be identified as ‘exceptions’ within SFBT. Furthermore, there was a sense that these events were processed during the therapy sessions.

3.6 Master Theme 5: Reflections on therapy

This theme includes the young people’s reflections on the range of improvements that occurred and their reflections on the therapy experience.
3.6.1 Range of improvements

Whilst the young people came to therapy to overcome specific problems they experienced changes in many areas of their lives. There was a strong sense that the young people experienced change as occurring gradually over the course of therapy, although Mike specifically experienced the initial session to have “helped a lot”. Chris, Alice, Ben and Mary reflected that the improvements occurred gradually over time:

Chris: “it's gradually getting higher and higher”

The young people all described a range of changes in their behaviour, affect and relationships within the family and outside of the family:

Mike: “I was settled in school and that”

Mary: “I felt brighter in myself...wanted to get out of bed in the morning”

Alice: “me and my mum...get on a lot better”

Furthermore, a number of the young people experienced a change in their self-esteem and confidence levels.

John: “I'm more happy and more confident”

Mary: “things that I could do all of a sudden that I couldn’t have seen myself doing before”

There was also a sense that therapy resulted in the young people developing new views of themselves. Alice for example commented that her experience of attending the clinic made her realise that “I wasn’t like an alien”. Chris on the other hand having completed therapy reflected that the experience “changes you...you feel like you are...somebody...nicer all round”. The experience of being respected and helped was particularly meaningful for Chris who experienced this as a sign that others understand that he is an individual with a difficulty rather than a ‘bad’ person:

Chris: “people want to help because they know that...we’re actually people who are nice who just have difficulty, and that's nice”.

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Mary and James also described holding a more positive outlook on life and that this led to experiencing life in a more positive manner:

**James:** “I get more out of life...don't see everything as negative and it's just much better”

### 3.6.2 Reflections on the therapeutic experience

The young people were encouraged during the interview to think back over their therapeutic experience. All individuals viewed the therapeutic experience generally positively and experienced therapy as bringing about change:

**Chris:** “helped me a lot”

**James:** “on the whole it's been really good”

Alice perceived the process of “having to open up has really, really helped”. Some of the young people experienced the ‘whole therapy package’ as helpful indicating that a combination of factors led to change. For James and Mary they seemed to experience the advice and techniques as helpful in conjunction with the positive therapeutic relationship:

**James:** “just all the techniques and them being friendly and not putting pressure on me”

**Mary:** “advice... just again having that person whose always there is nice”

I also invited the young people to make any suggestions about how the therapy experience could be improved for young people. Chris, John, Mary, and Mike did not feel that any changes should be made:

**John:** “it's not something that needs to be improved really”

**Chris:** “I think she did a perfect job”

Sarah acknowledged that the approach was of limited benefit to her as she felt that “all they could do was talk...I needed a more practical approach”. Ben suggested that it would have been helpful to either meet with the therapist prior to the first appointment or have some form of a briefing “just to say what was going to happen, and are you comfortable with that or do you want to change things”. James also felt that it would be helpful to warn young people in advance about the one-way mirror as he did not like this.
Ben experienced the waiting room as “tense” and “embarrassing”**. There was a sense that attending the clinic was embarrassing for him and a desire to conceal this in some way. John and Alice experienced some of the questions as confusing and difficult to answer and suggested that changes could be made to the format of questions:

**Alice**: “I think perhaps if they tried to sort of change the words maybe to make them more appropriate for children and people my age”

Some of the children interviewed by Lobatto (2002) also commented that therapists sometimes used “words that adults can understand and not children” (pp. 337) and found this excluded them from the therapeutic arena.

### 3.7 Master Theme 6: Control

This theme encompasses both the active participation of the therapist and the client in the therapy process and in initiating change. It is an overarching theme in the sense that it developed through looking at the way the young people described the process of change during therapy, and at times included their use of language when describing therapy and change. The position of the therapist varied and for many of the young people there was a clear awareness and respect towards the hierarchy of the therapeutic relationship. Bischoff and McBride (1996) found that the hierarchy of the therapist-client relationship was also meaningful to adults who attended couples therapy. In a number of transcripts it became clear that the young person developed a sense of being more in control over the course of therapy.

#### 3.7.1 Control over therapy

The young people in this study appeared to experience varying degrees of control over the process of therapy. This is also a measure of the degree of client participation in the therapeutic experience. The young people described times where the therapist was perceived as being in control, times when they were working collaboratively and times when control was given to the client. This varied between participants and appeared to
also change over the course of therapy. Mike and Chris for example experienced the therapist as in control of setting goals:

**Mike:** "*she used to like set targets*"

**Chris:** "*She just give us like me targets just to work towards*"

Alice on the other hand experienced goal setting as collaborative, and at a later stage in the interview Mike also perceived the setting of goals to occur collaboratively. Other individuals described how they took control of the process and set their own goals both in the sessions with the therapist and in the time between sessions. In Chris’ experience, the therapy relationship was also collaborative at times and he described this as "*a bit like a board game like you take turns*". The following quote from Mary highlights her sense of collaboration:

**Mary:** "*she was just trying to walk me towards a solution really*"

There were times however, when the therapist was perceived to be an ‘expert’, in control of the content of sessions and termination of therapy:

**Mary:** "*she’ll discuss what she wants to get out of that current session*"

**James:** "*and they [therapists] are going to say whether I need to see them anymore, or whether it’s improved enough.*"

For many of the young people, there was a sense of comfort that the therapist controlled some aspects of the therapy sessions whilst young people also wanted to have some control over some elements of the therapy process. In general, Ben felt that the therapists "*let me be in control of what’s happening*". Chris, Alice and John all appeared to appreciate times when they were in control in relation to making decisions about when to return for future sessions:

**Alice:** "*[Psychologist] actually asks me when I think it would be suitable for me to come back which I really like the idea of*"

Alice continued to explain that this was important to her as it enabled her to work at her own pace and have space to try out new ideas. However, she also experienced frustration that the therapist controlled what was talked about in the therapy conversations:

**Alice:** "*I got told that um they didn’t need to know about that*"
With the exception of Alice, the young people's experiences did not seem to involve a struggle for control over therapy, but more of a welcome balance where they appreciated being able to control some aspects of the process whilst also valuing aspects where the therapist would take control, for instance when the therapist directed the focus onto improvements. There was however a clear sense that the young people valued the opportunities to control the pace of therapy.

3.7.2 Control over change

Related to the sense of control within the sessions, a theme emerged around how the young people made sense of change. The young people viewed the therapist as helping to bring about change. Mary for example seemed to hold the perception upon entering therapy that the therapist would be the agent of change:

Mary: "I was very much hoping that she would be able to do something to help me, but no I couldn't really see how she was going to do that or about how that would come about"

Mike, John, James and Ben upon reflection seemed also to experience the therapist as important in the process of change:

Mike: "she helped me"

James: "see if it had increased or got better with the help she'd given."

On the other hand, the young people also seemed to experience the therapist as actively trying to encourage them to take control over their problems and explore how they had brought about this change themselves:

Mary: "what you've been up to and doing to help it"

Chris: "how did you\(^3\) do that like how did you solve that yourself"

Alice experienced the therapist's invitation to have control over the pace of therapy as an opportunity to think about the process of change and feel in control of this:

Alice: "let me think about how long I'll need until I'm ready"

\(^3\) The words are underlined to show that the emphasis placed on the word by the participant.
Ben further elaborated the theme of ownership of change when he described how he understood the therapist’s techniques as a direct attempt to help him feel more in control:

**Ben:** “I think they wanted to make me feel in control so that I’d feel in control more about my [problems]”

All of the young people seemed to take ownership of some of the changes that had occurred. James and Ben described how the ideas and suggestions that were discussed in the sessions were their own:

**James:** “actually I was surprised that ...the ideas that sometimes, well mostly all the time are mine”

**Ben:** “mostly it’s me doing the, suggesting what I want to try”

Sarah, Mary, John and Chris experienced a developing internal locus of control as they suggested that they were responsible for bringing about change in their lives:

**Sarah:** “I’m going to have to go do that by myself”

**Chris:** “I'm the one who's done it”

This finding fits with one of the aims of SFBT which is to help the individual develop an internal locus of control. Chris in particular seemed to end therapy with a sense that he had more control over his life and would be able to tackle new situations independently:

**Chris:** “I feel like, it’s time to do it more on my own, independently. ... to try it on your own and try techniques people have taught you, you know, in a way like helped you and then when you get in a situation on your own that’s bad, then you can just think like back I remember what she said like, I’ll try that technique out and then do it like that on your own, ... you’ll be more independent”

There was a sense that he had acquired transferable skills that would help him to overcome problems in the future. Whilst this experience was not expressed by all individuals, there was a sense that the majority of the young people experienced change as both coming from within themselves, and resulting from the therapeutic experience.
4. DISCUSSION

4.1 Discussion and summary of main findings

The young people in the current study were able to reflect on their experience of attending SFBT and were able to identify what, for them, were the active ingredients of change. The emerging themes highlighted that the young people's experiences were characterised by a number of key elements: the focus on strengths and improvements; feeling included and central to the process; provision of praise and reinforcement; personal commitment and self-motivation; control over the process of therapy; a developing sense of personal agency and the provision of suggestions and ideas from the therapist.

4.1.1. Focus on strengths and improvements

Attending the clinic was anxiety provoking as the young people did not know what to expect and worried about being negatively judged by professionals. This may be based on past experiences of being judged negatively or feeling blamed because of their difficulties. However, young people experienced SFBT positively as they were encouraged to focus on their strengths rather than their deficits. This made attending the clinic more pleasant and helpful as the individual felt respected and valued. ‘Problem-free talk’ communicated the message that the therapist was interested in them first, and then the problem. The problem was externalised and viewed as being separate to the young person, which enabled them to begin to explore alternative views of themselves. They experienced a setting whereby improvements and successes were noticed and reinforced. Whilst young people found that some opportunity to talk about their problems was helpful, there was a clear appreciation of the explicit conversational focus on improvements. Certain techniques were experienced as helpful in establishing a setting whereby success could be celebrated: praise and reinforcement; scaling questions; and a focus on achievable realistic goals.
4.1.2 Feeling included and central to the process

The young people experienced their role as active and central, and felt included within the therapy process. This is in contrast to Lobatto (2002), Stith et al. (1996) and Strickland-Clark (2000) who found that young people did not always feel included in family therapy, but were keen to be engaged when the focus was not on them solely. In the current research the young people appeared to be comfortable with the predominant focus on them. Stith et al. (1996) found that children were keen to be included in the development of solutions to problems but did not want their problems to be the focus of conversations. It may be that the SFBT emphasis on solutions and successes, rather than past failures, impacted on their comfort with being the focus of conversations and enabled them to be included in the process.

4.1.3 Provision of praise and reinforcement

The focus on success was especially enhanced through praise and reinforcement. The young people seemed to flourish in an environment where praise and reinforcement were plentiful. This may have contributed to their developing positive internal self-representation which clearly emerged in their descriptions of enhanced self-esteem and self-worth. They experienced praise from the therapist as enhancing motivation and self-belief in their ability to succeed. It could be speculated that praise was especially meaningful as it was explicit. The importance of praise and reinforcement has not emerged in previous studies exploring young people’s experiences of attending therapy. Research has consistently emphasised the importance of praise on children’s behaviour and self-esteem, and it is an inherent part of behavioural programs, for parents and teachers (e.g. Webster-Stratton, 1992). Extensive literature searches indicated that research has not specifically explored the use of praise as a technique within therapy. Pinsker (1998) proposes that praise is a component of supportive therapies which is overlooked within psychotherapy training, as the focus is directed towards theory driven treatments and techniques. Sprenkle et al. (1999) suggest that reinforcement is a common
therapeutic technique that has received little attention within the field of marriage and family therapy. I would imagine that clinicians working with children and adolescents would indicate that praise is an important part of their approach. SFBT places an emphasis upon this which may make praise more explicit than other approaches. It would also be interesting to consider whether the young people’s parents, having observed the therapist modelling a different way of interacting with their offspring, in turn praise and reinforce the young person outside of the therapy environment. Young people highlighted the importance of significant others in supporting them and as an opportunity to hear alternative perspectives, which could include the parents hearing their successes and praise.

4.1.4 Commitment and self-motivation

The young people in this study were committed to, and engaged with, the process of therapy and initiating change in their lives. Motivation, commitment and self-belief were key elements of their experience and identified as crucial in bringing about change. Motivation was facilitated by scaling questions, praise, and a clear definition of goals which were often experienced as evolving from their own hopes and aims. It could be hypothesised that individuals would be more motivated when working towards goals that are self-defined and relevant to them, than when aims are decided by their parents or therapists. Being included in the decision about coming to the clinic helped some individuals to feel motivated upon entering therapy. Thus motivation was important upon entering therapy and harnessed during therapy. This meant that the young people had the confidence to try out new ideas, leading to more opportunities for reinforcement and praise both through their experiences and the therapy process, which then further impacted on their motivation and confidence. Asay and Lambert (1999) highlight that client motivation is one of the most frequently mentioned client variables that positively impacts upon outcome, which is supported by the young people’s experiences in the current study.
4.1.5 Control over the process of therapy

Another key element of the young people's experience was the importance of being in control. They experienced varying degrees of control over the process of therapy. Being in control enabled them to be active within the therapy process and also in control of overcoming their difficulties, and owning their successes. This may be especially important for young people who generally have very little control over many elements of their lives as a result of their age. This process of being in control could therefore be crucial in enabling young people to have faith in their ability to control and overcome their problems. Developmentally adolescence is a time when individuals negotiate increased control and independence, thus being able to control the process of therapy and change is important at this time in their lives (Lanyado, 1999). In conjunction with this, the active involvement of the therapist was appreciated and there was a balance between the therapist directing therapy and the young person being in control. The young people entered therapy requiring different degrees of control over the process, which also developed over the course of therapy. Some young people, for example, may initially need the therapist to control most of the process of therapy and then hand over this control as and when they are ready to take this. This is likely to be influenced by a number of factors (e.g. age, developmental stage, experiences of control in other relationships) and the task of the therapist is to determine this and respond appropriately.

Control, motivation, praise and being included in therapy seem to be closely related. It might be that being included and in control helps young people to feel motivated. However, it may also be that praise from the therapist helped the young people to feel motivated which enabled them to take control. This is likely to be a circular relationship with each element impacting on the others.
4.1.6 Developing sense of personal agency

Many of the young people experienced a developing sense of personal agency and internal locus of control. They developed beliefs about their own ability to control their difficulties. The attribution of success in therapy to their own abilities is likely to impact on their developing sense of self-efficacy and belief that they can influence their life circumstances (Bandura, 1981; cited in Carr, 1999). Being in control of the process of therapy contributed to the developing internal locus of control and the young people experienced the therapist as actively encouraging them to take control and ownership of their successes. Dermer et al. (1998) suggest that the language used within SFBT fosters an internal locus of control and the current participants’ experiences support this to some extent as they were all able to take some credit for the changes that occurred. High self-efficacy and an internal locus of control may also serve to protect the young people in the future (Carr, 1999).

4.1.6 Provision of suggestions and advice from the therapist

The therapist providing suggestions, advice or ideas to the young person was perceived to be another key element of the process. In line with Metcalf et al. (1994) the therapist’s advice and suggestions were valued and appreciated by the young people. It is interesting to note that within SFBT, therapists are discouraged from making suggestions and taking a directive role. However, the current study suggests that this is a helpful and valued aspect of therapy (Metcalf et al. 1996). In particular, it seemed that the therapist was presenting one of many possible solutions rather than providing the ‘right’ solution. Their use of language highlights the perceived element of choice as therapists were described as “offering ideas” or “making suggestions”, rather than telling the young person what to do. This in turn meant that the therapist’s solutions were not privileged over the young person’s and could therefore be tried out and either rejected or accepted as appropriate. This might be quite different to the young people’s experiences in other environments where they are required to obey or defer to adults.
4.2  **Relation to the ‘common factors’ of therapy**

In the current study, clients attributed successful outcome to a combination of relationship factors, client factors and specific SFBT techniques. There are therefore parallels in the current research with Lambert’s (1992/2003) ‘common factors’ of therapy. Whilst this may not be surprising, it suggests that despite developmental differences to adults, the young people also experienced certain ‘common factors’ as responsible for successful outcomes. They experienced a therapeutic relationship and indicated that the therapist’s personality and attitude were important. In terms of client factors, client motivation was understood to be an essential factor which enabled young people to overcome their difficulties. Metcalf et al. (1996) suggested that SFBT may be meaningful through enhancing some of the common factors of therapy. The current research supports this but extends the findings of Metcalf et al. (1996) and suggests that specific SFBT techniques may enhance the therapeutic relationship and harness certain client factors. In the current study, in contrast to Metcalf et al. (1996), the young people spontaneously identified certain SFBT techniques as important in both the process of therapy and change. Firstly, the SFBT technique of ‘problem free talk’ was perceived to reduce their anxiety and facilitate the development of a positive therapeutic relationship. It is interesting to note the importance the young people attributed to the relationship, as this has received little attention within SFBT. Secondly, the young people thought that scaling questions and praise from the therapist helped to increase their motivation and self-esteem. It is likely that the techniques were effective and valued by the young people as they occurred within the context of a trusting relationship (Young, 2005). It is interesting to note how the young people experienced techniques of SFBT as important whereas the adults interviewed by Metcalf et al. (1996) did not mention these techniques. It may be that for children and adolescents, the structure and concrete nature of the techniques, facilitates the therapy process whereas adults are less dependent upon these techniques and they are therefore less significant.
4.3 **Diagrammatic Representation of how themes relate and overlap**

Figure 1 shows how I came to conceptualise the relationship between the themes. In the process of mapping out the themes, I came to understand them to be related in this way, although this is a personal conceptualisation with the aim of facilitating the reader in understanding my view of how the themes interact. I did not perceive there to be a hierarchy within the themes and therefore presented them on a linear plane. However, the size of the spheres represents my understanding of the relative presence of that theme within participants’ accounts. As is clear from the diagram, I conceptualised the theme of control to relate and overlap with all the other themes and viewed this as something that the young people felt was important at all stages of the therapeutic experience. The linear plane also represents what I began to see as the young people’s understanding of the process of therapy, starting with the importance of their entrance to therapy, moving on to the active ingredients of therapy (including elements of SFBT, other facilitative factors and the therapist relationship factors) and resulting in opportunities to reflect on the process and the range of improvements. The cluster of overlapping themes in the middle represents my understanding that how young people viewed aspects specific to SFBT, the therapeutic relationship, and additional facilitative factors (e.g. motivation, presence of significant others) to relate and contribute to effective therapy and change.
Figure 1: Visual representation of how themes relate and overlap

Key

1. Control
2. Entrance to therapy
3. Elements of SFBT that supported the change process
4. Facilitative factors in the process of change
5. Reflections on therapy
6. Therapist relationship factors
4.4 **Clinical implications and further research possibilities**

The young people in the current study have brought to light how praise, in conjunction with a focus on strengths and improvements, may be an important element within therapy, impacting on both their self-esteem and their engagement with the therapy process. It may be that researchers and clinicians have overlooked the importance of praise within therapy, and it would be beneficial to reconsider the use of praise within therapy and the potential impact this can have both on motivating individuals and improving self-esteem. This is particularly important as many young people who present to Child and Family services are likely to have low self-esteem. Further research could explore this explicitly and focus on the types and delivery of praise that are most effective. The current findings could also suggest that a focus on the young person’s strengths, present successes and the future, rather than a focus on past failures, are useful techniques to engage the young person and may reduce the likelihood of individuals dropping out of therapy. Furthermore, considering the importance young people attributed to motivation, research could explore this further to gain further understanding of how motivation may be harnessed during therapy.

The SFBT technique ‘problem free talk’ reduced anxiety and facilitated the development of the therapeutic relationship. Whilst this may not be a technique that is isolated to SFBT, it may be significant that within SFBT it happens in the first appointment before any other discussions. This therefore establishes a model of how the individual is received, that is, person first with difficulties second. This shapes the mindset of both the therapist and young person and helps the individual to feel valued and respected as a person rather than a problem. Clinicians working with young people should therefore consider the benefit of talking with young people about areas other than the problem before focusing on the difficulties that bring them to therapy. Further research could explore the importance of ‘problem free talk’ on the development of the therapeutic relationship. The young people also emphasised the importance of the therapist’s
personality, and it may therefore be helpful to include young people in the interview process when recruiting staff for child and family services.

The current research suggests that young people appreciate and value therapists' suggestions and the perception of the therapist as an expert. I would suggest that this points to a crucial balance where the client and therapist are understood to both hold expertise rather than focusing exclusively on one individual's expertise at the expense of the other. This challenges the SFBT assumption of the client as the expert and suggests that client's found it helpful to view both themselves and their therapists as experts. The provision of these suggestions or ideas was within a context where the young people were encouraged to see this as one of many potential solutions. This suggests a way for clinicians to position their suggestions to young people whilst also encouraging them to develop their own solutions. Further research could look at the meaning of advice from the client's perspective in more detail.

It also seems important to encourage young people to play an active role in therapy and this can be facilitated by placing some control in their hands, at the level that fits for the young person. It would be interesting to further explore the meaning of control with young people and how this is negotiated. In the current study, a sense of control over the process of therapy resulted in a sense of control over their difficulties, the future and change. It would also be interesting to interview therapists about how they make decisions about control and the factors that influence these decisions. Further research could also explore whether SFBT impacts upon individuals self-efficacy beliefs and locus of control.

The current research indicates that young people can provide in-depth and insightful descriptions of their experiences of therapy through semi-structured interviews. Whilst variation existed in their ability to articulate and explain their experiences, the combination of participants of different abilities and verbal expression facilitated the process of understanding, as some young people were able to put into words the meaning
of experiences that others struggled to articulate. One of the participants found the open-ended nature of the interview schedule difficult and it was necessary throughout to prompt and provide forced choice questions to facilitate the process. It may be helpful when eliciting young people’s views to engage in a variety of research methods to facilitate individuals in expressing their views on the experience. It would also be interesting to explore how different psychotherapy approaches are experienced by young people, to further explore the elements that may be specific to certain models or common across psychotherapies. Future research could also explore parents’ experiences of attending the SFBT clinic with their children.

4.5 Service implications

The results of the study will be disseminated through a variety of methods. A meeting has been scheduled to present the findings of the study at the Child and Adolescent Mental Health Service where the research was conducted, and at a local Child Psychology Meeting. It is anticipated that this will generate discussions with regards to how the SFBT clinic is run and pertinent issues in relation to how young people experience therapy and change. The broader applicability of the research will be discussed at a Continuing Professional Development (CPD) conference for trainee clinical psychologists and regional psychologists held in Surrey.

In addition to the clinical implications described above, some specific suggestions emerged for the SFBT clinic and service where the research was set. Firstly, the young people highlighted how attending the clinic was anxiety provoking. It may be helpful to provide young people with information about what will happen, prior to their first appointment, to reduce their anxiety. This could be achieved through the development of flyers or leaflets that could be distributed by the referrer at the time of referral or sent out with the appointment letter. Young people could be consulted with and included in the development of these leaflets. This would also enable young people to be included in the
decision about attending therapy and could increase motivation, and decrease the number of individuals who do not attend initial appointments.

Secondly, when asked to comment on the process of taking part in the research, some of the young people described how this process of reflecting on their experience was helpful in processing the change that had occurred:

**James:** “it’s made me see what I’ve discussed, and to see that it definitely has helped”

It may therefore be beneficial for clients to have an opportunity to reflect on their therapeutic experience. Metcalf and Thomas (1994) suggested that once clients have met their goals it may be beneficial to instigate a conversation about how change has occurred. Whilst providing space for the client to reflect, this would also provide the service with valuable information about what contributes to meaningful and effective therapy for clients. An ongoing process of client reflection and feedback on services would ensure that service users are involved and would also contribute to the development of practise-based evidence. Whilst the young people identified specific goals and problems to overcome at the outset of therapy, they described how the experience had resulted in a range of improvements. This included change in their behaviour, affect, thoughts, relationships, self-esteem, locus of control (from external to internal) and confidence. There was an overall sense that the individual’s quality of life in general had improved. The psychologist’s running the SFBT clinic should therefore consider measuring a range of outcomes alongside symptom reduction or achievement of goals. It might be helpful, for example, to measure the young people’s locus of control and self-efficacy beliefs.

Thirdly, whilst the majority of the young people in the current study appreciated the focus on improvements rather than problems, one individual had not felt heard by the therapist when she was directed away from talking about the problem. This suggests that for some individuals it may be important to be able to talk about their problems in more detail. It might be helpful to explore individual’s model of change and expectations in the early
sessions and think about the significance of matching their approach to this model. However, therapists working within SFBT would argue that the discussion of problem-saturated discourses reinforces and perpetuates this discourse and should therefore be avoided. The question therefore lies in how the individual’s story can be heard whilst not feeding into the negative discourse. Further research could explore whether successful therapy from the young person’s perspective is affected by the fit between their model of change and the model of change underlying the therapy model.

4.6 Limitations

The findings described in the current study are only one possible interpretation of the young people’s experiences of attending SFBT. It is possible that another researcher, at a different time, with different values and beliefs, would focus on different areas of the data and produce a slightly different interpretation of the young people’s experiences. However, it is unlikely that another researcher would develop a completely different interpretation as a number of validity and credibility checks were conducted throughout the research process (see section 2.7).

It is important to note that the current research is limited in the extent to which the findings can be generalised beyond the sample used in the current study. Only two therapists were involved in the research and therefore the current findings are a reflection of their unique practice and interpretation of SFBT. Furthermore, the majority of individuals in the current study were young people who were successfully engaged in the process of therapy. A number of potential participants could not be accessed as a result of early termination from the clinic. It is possible that the sample is skewed towards those that were effectively engaged and attending. However, those that did not return for appointments were both individuals who felt that they no-longer needed sessions and individuals who were not engaged in the therapy process. It would be interesting to include individuals who have not engaged with the therapeutic process to explore and
gain understanding of their experience as this may lead to information about how to improve the experience and lead to more meaningful and effective therapy.

A potential criticism of the current study is the lack of triangulation of perspectives. Triangulation of perspectives is one way of expanding our understanding of the phenomenon under investigation and is a way to enhance the validity of the findings (Dallos & Vetere, 2005). This could be through interviewing other members of the therapy system such as parents, siblings or therapists about their perceptions of the young people’s experience. However, as a result of past tendencies to exclude young people from research of this nature, the current study aimed to explore and understand young people’s experience of SFBT solely from their perspective. The young people may have felt undermined if their parent’s views were also being sought and this might have implied that I was searching for the ‘truth’. However, further research could seek these triangulated perspectives and also explore parents’ unique experience of attending SFBT with their child from their perspective.

Whilst the rationale for not checking back with young people was described in the method section (2.7.1), it could be argued that gaining this feedback would have contributed to the process of hearing young people’s voices and strengthened the credibility of the research. In the current study, young people received a summary of the research and were invited to contact the researcher if they had any questions or comments on the results. However, in future research I would consider talking with young people at the outset about the importance of ensuring that I have understood them and represented their views appropriately, and then ask them whether they would be prepared to comment on the emerging analysis in a more structured format. A feedback form could have been produced and sent out with the summary asking young people to comment on the themes and interpretations and how well this fitted with their own ideas. Alternatively, it may be most useful to meet with young people again and incorporate their comments in the emerging analysis. It might be that including a young person as a co-researcher and in
gaining feedback would also support this process and help to reduce the likelihood of the participant deferring to the researcher.

The use of IPA in the current study enabled exploration of the shared experiences of young people whilst also capturing some of the divergence in their experiences, and unique differences. I chose to focus predominantly on the shared experiences of the young people as I was interested in gaining a generalised understanding (Willig, 2001), but also highlighted how individuals experiences differed in the discussion of the themes in the results section. As would be expected, the young people’s therapeutic experiences differed. I therefore considered whether unique emerging themes were isolated to the individual and a result of their unique experience or were shared with others. This was taken into consideration at the analysis stage when pervious transcripts were explored to see if additional evidence of new themes existed in other individuals’ accounts. The difference in therapeutic experience of the young people was most apparent in the case of Mary, who attended more therapy sessions over a longer period than the other participants. In her account, the importance of the consistency and longevity of the therapeutic relationship was extremely apparent as she described how helpful it had been to have the support of the therapist over a two year period. This was unique to Mary and seemed to be a result of her different therapeutic experience. As is necessary in qualitative research of this nature which often generates a large amount of data, certain aspects were selected for exploration in the discussion section and others not. A case study approach may have enabled a more in-depth understanding of the young people’s individual experiences. I considered incorporating further discussion of Mary’s unique experience possibly in the form of a mini case study, but decided that this would compromise her anonymity. Further research of this nature could be considered in light of the current findings and would complement and enrich the current study.
4.7 Self-reflections on the research process

As a newcomer to qualitative research methodologies the process of conducting the current study has opened my eyes to a number of issues. In particular, the process of conducting literature reviews and reading previous research during the interview and analysis phase may have biased my interpretation in the current study. For example, having read about the foundations of SFBT and the intended aims of the approach I may have probed more when young people mentioned certain techniques. Similarly, my knowledge of the importance of the ‘common factors’ of therapy may have influenced the avenues that I explored in the interview. I tried to be aware of these potential biases and monitor myself during and after the interviews by re-reading transcripts and thinking about other avenues to explore. Furthermore, my knowledge of the SFBT approach is likely to have impacted upon the analytic process. I was aware that I was using the language of the approach and other researchers may have paid attention to different information or labelled this differently. However, as far as possible I attempted to analyse the young people’s data on their own terms, integrating theory directly after this analysis (Reed, forthcoming). This was therefore guided by the emerging themes from the study and shows how the current research fits in with previous research.

One of the dilemmas when researching young people as both an adult and a professional within clinical psychology is the impact of the researcher’s position on the researcher – participant relationship. I discussed ways to reduce the power difference between myself and participants in the methodology section. However, this is likely to have continued to impact on the interview process. Dockrell et al. (2000) suggest that having young people as interviewers of other young people can increase the naturalness of the setting and may yield different information. Further research could take this forward and include a young person with experience of attending therapy as a researcher and interviewer.

Grafanaki (1996) highlights that the process of conducting qualitative research will inevitably change the researcher both personally and professionally. Upon reflection, I
became aware of the impact of the research both on myself as an individual and my identity and practise as a clinical psychologist. In particular, the process illuminated some assumptions and biases that I held. I became aware that to some extent I had reservations about young people's ability to reflect on their experiences in a meaningful way. I wondered if this was influenced by previous culturally held beliefs that young people would not be the best informants of their own experiences, as described in the introduction section. I was surprised that I held this anxiety as I was motivated to complete the study because I was keen for young people to have an opportunity to reflect on their experiences. This seemed to be an anxiety that was exacerbated through discussions with other researchers and clinical psychologists who appeared to doubt whether young people would be able to respond to the open-ended nature of the interview. This assumption has however been strongly challenged through the process of completing the interviews and analysing the data. I also became aware that I held the belief that female participants may be more reflective and articulate than male participants. I think this stemmed from gender stereotypes and was a belief that was also challenged in the present research. Having completed this research, I am much more aware of how much young people can contribute to our understanding of the world. I am keen in my future practise to integrate a process of reflection into my work with young people and use what they say to improve my own practise.

I have learnt a great deal about how to effectively ask questions when eliciting young people's views and my tendency to ask long-winded and complicated questions. I observed this through the process of transcribing and re-reading the transcripts. This also reminded me of the importance of recording and reflecting on my own clinical practise regularly and how much can be gained through observation of our own work. This has also impacted on both my interactions with young people in my personal life and clinical practise. I also noticed that as I became more skilled and confident as an interviewer I was more able to depart from the interview schedule and engage the young people in more natural conversation about their experiences. As my skills developed, the young people's accounts seemed to become richer. This highlighted how significant the
researcher is within the process of the research in enabling the interviewee to 'tell their story'. At times I found the researcher role quite restrictive, as it was difficult to put aside the more natural tendency to engage therapeutically with the young people, and focus on the research questions.

One of the challenges of engaging with a qualitative research project of this nature, was striking a balance between providing an interpretative account which goes beyond the descriptive level of the data, and remaining truly grounded in the data. Whilst this was anxiety provoking at times, I enjoyed the opportunity to think creatively about the data and also found that it was extremely useful to have discussions with other qualitative researchers about ways of managing this tension. This has taught me that the process of analysis and interpretation in qualitative studies is ever evolving. The process of conducting credibility checks and discussing emerging themes with other researchers, highlighted how interesting and enriching it was to be able to discuss emerging ideas with others. This served to both check the credibility of the emerging analysis but also helped to 'open my eyes' to other interpretations and views of the data. I was generally surprised that different researchers with different experiences nevertheless seemed to identify similar themes. When carrying out qualitative research of this nature in the future, I think I would personally find it beneficial to work closely with co-researchers as I found that I benefited from opportunities to discuss emerging themes and ideas with colleagues.

The findings from this research have also significantly impacted on my practice as a clinical psychologist. The findings reminded me of the importance of praising young people and how this not only increases motivation but impacts positively on their developing sense of self and self-worth. I wondered whether control was a significant theme for these young people as a result of their developmental stage and adolescence being a time when young people are negotiating increased independence and control over their lives. I will be more aware of how control within the therapeutic relationship is negotiated and the importance of enabling young people to make choices and be in control of the therapeutic process. Through engaging in the research I have also begun to
think more about the importance of 'fit' between the client and the model of therapy. I would be keen to explore with individuals that I work with in the future, their own views and models of change at the outset of therapy. Furthermore, whilst the young people reflected on the importance of the therapeutic relationship and certain SFBT techniques, I was humbled by their accounts of how self-motivation and hard work were integral in bringing about change. Whilst I had expected young people to describe their experiences positively, the current research has encouraged my interest in therapeutic approaches that focus on clients resources rather than approaches that focus on deficit and pathology.

4.8 Conclusions

The findings of this study show that young people's perceptions and experiences of therapy can be helpfully elicited through semi-structured interviews. The young people were able to reflect on the meaningful aspects of the process of therapy and change. This provides valuable information for services and clinicians working with young people. The young people in the current study valued the creation of a setting whereby successes could be celebrated, and where they received praise from the therapist. Self-motivation, feeling actively included and being able to be in control of the therapy process were central to their experience.
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Appendix 1 – SFBT Techniques
Description of SFBT Techniques

1. **Problem-free talk** – The therapist invites the client to talk about aspects of their life apart from the issue bringing them to therapy. Within this discussion the therapist explores areas of competence within the client’s life. The therapist will also ask the client to describe their past before the problem existed.

2. **Goal clarification** – The client is encouraged to develop specific and measurable goals for therapy (Wheeler, 2001).

3. **Exploring Preferred Future** - The client’s ‘best hopes’ for either the session or therapy as a whole are explored to shift the conversation towards the future and help define goals for therapy. The ‘miracle’ question may be introduced to help clients to identify and describe the future they are aiming for:

   “Imagine tonight, while you are asleep, a miracle happens and your hopes from coming here are realised (or the problems that bring you here have been relaxed), but because you are asleep you don’t realise this miracle has happened. What are you going to notice different about your life when you wake up that begins to tell you that this miracle has happened?” (George et al. 2002, p.6)

4. **Exceptions** – This includes asking questions about what is already working for the client, exploring any changes that the client has made since deciding to seek therapy, and eliciting examples of when the difficulty is less, absent or easier to cope with (Letham, 2002). If the therapist has asked the miracle question they might inquire about times when the miracle is already happening or glimpses of their preferred future (George et al. 2002).
5. **Scaling questions** - This technique is employed to facilitate the client to explore small changes and develop realistic goals for the therapy (George et al. 2002). The client is asked to rate where they see the situation currently on a scale of 0 to 10, with 0 representing the worst things could be and 10 representing the way the client would like things to be. The therapist will then explore with the client what is right in their life, for example by asking "what is it that tells you that you are at a 3 and not at 0?" or if the client were in fact to answer that life was at 0, the therapist may inquire about the resources that are enabling them to cope, persevere and remain determined despite the problem. Following this exploration the therapist will begin to explore the signs the client would notice to indicate that they have moved up one point on the scale.

6. **Compliments** – This occurs in all sessions and involves the therapist giving the client constructive feedback about what resources, skills, strengths and abilities the client has which have emerged through the conversation and highlight what the client is already doing that they have found helpful. These messages are useful in supporting the conversational shift towards solution-orientated conversations (George et al. 2002). The therapist might make a suggestion at the end of the session which is intended to encourage the client to observe or notice any signs of progress, or encourage the client to do more of the things that they have identified as useful.
Appendix 2 – Copy of Ethical Approval Letter from West Sussex Local Research Ethics Committee
Dear Miss Tilley

Full title of study: An exploration of young people's experience of attending solution focused brief therapy; their understanding and views of the meaningful aspects of therapy and change.

REC reference number: 05/Q1911/44
Amendment number: 1
Amendment date: 03/02/2006

The above amendment was reviewed at the meeting of the Sub-Committee of the Research Ethics Committee held on 20/02/2005.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Covering Letter dated 03/02/2005
Notice of Substantial Amendment form dated 03/02/2006
Protocol version 3 dated 03/02/2006
Participant Information sheet (16+) version 2 dated 03/02/2006
Participant Information sheet (11-15 year old) version 2 dated 03/02/2006
Participant Information sheet (parents) version 3 dated 03/02/2006

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Research governance approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.
Statement of compliance

The Committee is fully compliant with the Regulations as they relate to ethics committees and the conditions and principles of good clinical practice.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q1911/44 Please quote this number on all correspondence

Yours sincerely

Mrs Nischinth Cherodian
LREC Administrator

Email: nischinth.cherodian@wash.nhs.uk

Copy to: Mr Terry DeSombre
The University of Surrey
Guildford
Surrey
GU2 7XH

R&D Department for NHS care organisation

List of members present at meeting on 20/0/2006

Dr Andrew Nayagam – Consultant on HU/HIV Medicine (Chair)
Dr Jeremy Quiney – Consultant Chemical Pathologist
Appendix 3 – Copy of Ethical Approval Letter from University of Surrey Ethics Committee
06 March 2006

Ms Jodie Tilley
64A Forest Road
WORTHING
West Sussex
BN14 9LT

Dear Ms Tilley

An exploration of young people's experience of solution focused brief therapy: their understanding and views of the meaningful aspects of therapy and change (EC/2005/83/Psych) - FAST TRACK - Amendment

I am writing to inform you that the Chairman, on behalf of the Ethics Committee, has considered the Amendments requested to the above protocol and has approved them on the understanding that the Ethical Guidelines for Teaching and Research are observed.

Date of confirmation of ethical opinion: 16 August 2005

Date of approval of amendment to protocol: 06 March 2006

The list of amended documents reviewed and approved by the Chairman is as follows:-

Document Type: Your Letter Requesting Amendments with Amended Protocol
Dated: 23/02/06
Received: 24/02/06

Document Type: Letter from the West Sussex LREC Approving Amendments
Dated: 20/02/06
Received: 24/02/06

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Ms M John, Supervisor, Dept of Psychology
Appendix 4 – Copy of Approval Letter from West Sussex Local Research and Development Department
Dear Miss Tilley

ID: 0562/NOCI/2005  An exploration of young people's experience of attending solution focused brief therapy: their understanding and views of the meaningful aspects of therapy and change.

Further to the initial study approval letter on 29th July 2005, a protocol amendment has been received. The RAMC sub-committee have considered this additional information. The document/s considered was/were as follows:

* Protocol (version 3 dated 03/02/06)
* Participant Information sheet - parents (version 3 dated 03/02/06)
* Participant Information sheet - 16+ (version 2 dated 03/02/06)
* Participant Information sheet - 11-15 year olds (version 2 dated 03/02/06)
* COREC notice of substantial amendment form (unsigned and undated)
* West Sussex LREC amendment approval letter (signed and dated 20/02/06)

I am pleased to inform you that this amendment has received approval. This approval is valid in the following Organisations:

* West Sussex Health and Social Care NHS Trust - Chichester Child and Family Service for Mental Health, Orchard House

Your RAMC approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
2. You notify the RAMC by contacting me, should you deviate or make any changes to the RAMC approved documents.
3. You alert the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS Organisations; such an extension can usually be arranged within five working days.

Good luck with your work.

Yours sincerely,
Helen Vaughan (Mrs)
Research Governance Assistant
Appendix 5 – Participant Information Sheets – Young people aged 11-15
I am a Trainee Clinical Psychologist from the University of Surrey. As part of my training I am trying to find out what it is like for young people attending the Clinic. Please read this information carefully and discuss it with others if you wish. It is important that you understand why the research is being done and what you would have to do. Please ask me if there is anything that is not clear or if you would like more information.

Thank you for reading this.

Why me?

We've asked you because you are aged between 11 and 18. We want to know what people of your age think about the Clinic. I am hoping to talk with between 10 and 15 young people who are attending or have recently finished therapy.

Do I have to take part?

It is up to you and your parent (or guardian) to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep. You and your parent/guardian will be asked to sign a form which says that you are happy to take part.

If you do decide to take part you can change your mind and pull out at any time, without giving a reason. This will not change any help you might receive from the Child and Family Service.
What do I have to do?

If you decide to join in you will talk with me for about 30 minutes to one hour. I will ask you about the things you can remember about coming to the Clinic. The interviews will be recorded on a tape.

**** or **** will be around to talk more if you need to. The interview will take place at the clinic.

You don’t need to prepare in any special way for the interview. I am interested in hearing what you think.

Are there any risks?

Sometimes, some people find talking about coming to the Clinic a bit upsetting. It is unlikely that you will feel like this, but if you do:

- I am a trainee clinical psychologist and you can talk with me
- You can talk with **** or **** afterwards.
- We can stop the interview at any point and no one will mind.

Some people might feel nervous about talking with me. If it would help, you can have a friend or family member come in to the interview with you so you feel more comfortable.

Will I gain anything?

Some young people enjoy having an opportunity to express their views about services. They feel respected and listened to. The information we get from the study may help us improve therapy for young people in the future. There will be no direct gains for you.

What if something goes wrong?

It is unlikely that anything would go wrong. However, if you do feel that something has happened that you do not like, you (or your parent/guardian) can contact **** or **** they will help you to make a complaint. You can also contact the Patient Advice and Liaison Service (PALS) on ***** *****. PALS is a confidential service to
support clients, relatives and carers and acts independently when seeking resolutions.

**Will what I say be kept private?**

**** and **** will NOT be allowed to listen to your interview. I will type everything we say in the interview onto a computer and the tape will then be wiped. I will use a letter instead of your name, and change or take out any information that would identify you. I will not say your name when I talk with supervisors who will help me with the research or when I write about the research. In the reports I might write out parts of what you said in the interview. No one will be able to know which young person said this.

**What happens to what the researcher finds out?**

I am doing this as part of my training to be a Psychologist. It will form part of the work I hand in for examination. A copy of the research will be kept in the library at the University of Surrey. I also hope that the results will be published for other professionals to read. I will share what we find out with other professionals so they can learn from this too. All details that are personal to you will be changed or taken out of any report or talks that I give. I will make copies of any published work available once these have been completed. These will be located in Clinic for you to access.

I will also write a summary of the research for all young people who have taken part. You would be able to get a copy of this in the post or we could find a time to meet and talk about this.

**Has anyone checked the study?**

The research has been checked by several people to make sure that it is alright.
What do I do now?

If you decide to join in please complete the enclosed Participant Reply Slip and send it to me in the envelope provided. I will then contact you.

How can I find out more about this study?

If you would like to find out more about the research please ring me on ***** *****.

If you agree to take part in this study you will be given a copy of this information sheet and a signed consent form to keep.

Thank you for reading this information.

Jodie Tilley
Trainee Clinical Psychologist
Department of Psychology
School of Human Sciences
University of Surrey
Guildford GU2 7XH
Appendix 6 – Participant Information Sheet – Young people 16-18 years old
PARTICIPANT INFORMATION SHEET
(16-18 year-olds)

Research Title:

Young people's experiences of attending the Solution-focused Therapy Clinic

What is the research for?

I am a Trainee Clinical Psychologist from the University of Surrey. As part of my training, I am carrying out a research study to find out what it is like for young people who have attended the Solution Focused Clinic.

I am hoping to find out what young people think about the Clinic, what it was like to attend, and what (if anything) was important.

Before you decide whether you would like to join in, it is important for you to understand why the research is being done and what you would have to do. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

Thank you for reading this.

Why me?

You are being asked to take part because you are between the age of 11 and 18 and you have attended this type of therapy at the Clinic. I am hoping to talk with between 10 and 15 young people who are attending or have recently finished therapy.

Do I have to take part?

It is up to you whether or not to take part. If you do decide to take part you will be given this information sheet to keep. You will also be asked to each sign a form which says that you are happy to take part.

If you decide to take part you can change your mind and pull out at any time, without giving a reason. This will not change any help you might receive from the Child and Family Service.
What do I have to do?

If you decide to take part, you will talk with me for about 30 minutes to one hour. I will ask you about the things you can remember about coming to the Clinic. The interviews will be recorded on a tape.

**** or **** will be around to talk more if you need to. The interview will take place at The clinic.

You do not need to prepare in any special way for the interview. I am interested in hearing your views.

Are there any risks?

Some people may find talking about coming to the Clinic a bit upsetting. It is unlikely that you will feel like this, but if you do:

- I am a trainee clinical psychologist and you can talk with me
- You can talk with **** or **** afterwards.
- We can stop the interview at any point and no one will mind.

Some people might feel nervous about talking with me. If it would help, you can have a friend or family member come in to the interview with you so you feel more comfortable.

Will I gain anything?

Some young people enjoy having an opportunity to express their views about services they have attended. They feel respected and listened to. The information we get from the study may help us improve therapy for future individuals and help the team think about young people’s views. There will be no direct gains for you.

What if something goes wrong?

It is unlikely that anything would go wrong. However, if you do feel that something has happened that you do not like, you can contact the person you met with and they will help you to make a complaint. You can also contact the Patient Advice and Liaison Service (PALS) on ***** *****. PALS is a confidential service to support clients, relatives and carers and acts independently when seeking resolutions.
Will what I say be kept private?

**** and **** will NOT be allowed to listen to your interview. I will type everything we say in the interview onto a computer and the tape will then be wiped. I will use a letter instead of your name, and change or take out any information that would identify you. I will not say your name when I talk with supervisors who will help me with the research or when I write about the research. In the reports I might write out parts of what you said in the interview. No one will be able to know which young person said this.

All personal data (e.g. consent forms) will be stored at the Clinic. The researcher will store the written version of the interview for 5 years, as required by the University of Surrey.

What happens to what the researcher finds out?

I am doing this as part of my training to be a Psychologist. It will form part of the work I hand in for examination. A copy of the research will be kept in the library at the University of Surrey.

I also hope that the results will be published for other professionals to read. I will share what we find out with other professionals so they can learn from this too. All details that are personal to you will be changed or taken out of any report or talks that I give. I will also write a summary of the research for all young people who have taken part. You would be able to get a copy of this in the post or we could find a time to meet and talk about this. I will make copies of any published work available once these have been completed. These will be located in Clinic for you to access.

Has anyone checked the study?

The research has been checked by several people to make sure that it is alright. The West Sussex Local Research Ethics Committee, The University of Surrey Ethics Committee, and the Sussex NHS Research Approval and Monitoring Committee have all reviewed and approved this study.

What do I do now?

If you would like to take part in the study please complete the enclosed Participant Reply Slip and send it to me in the envelope provided. I will then contact you.
How can I find out more about this study?

If you would like to find out more about the research please ring me on ******.

If you agree to take part in this study you will be given a copy of this information sheet and a signed consent form to keep.

Thank you for reading this information.

Jodie Tilley
Trainee Clinical Psychologist
Department of Psychology
University of Surrey
Guildford GU2 7XH
Appendix 7 – Participant Information Sheet – Parents version
PARTICIPANT INFORMATION SHEET  
(Parents version)

Research Title:

Young people's experiences of attending the Solution-focused Therapy Clinic

What is the research for?

I am a Trainee Clinical Psychologist from the University of Surrey. As part of my training, I am carrying out a research study to find out what it is like for young people who have attended the Solution Focused Clinic.

I am hoping to find out what young people think about the Clinic, what it was like to attend, and what (if anything) was important.

Before you and the young person decide whether to join in, it is important for you to understand why the research is being done and what the young person would have to do. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

Thank you for reading this.

Why have they been chosen?

Your child (or the young person you have parental responsibility for) is being asked to take part because he or she is between the age of 11 and 18 and has attended this type of therapy at the Clinic. I am hoping to talk with between 10 and 15 young people who are attending or have recently finished therapy.

Do they have to take part?

It is up to you and the young person to decide whether or not to take part. As the young person is below the age of 16 your consent is also being sought. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. The young person will also be asked to sign an assent form which indicates their agreement to take part. If you and the young person decide to take part they are still free to pull out at any time and without giving a reason. This will not change any help you might receive from the Child and Family Service.
What would they have to do?

If you decide to take part, the young person will talk with me for about 30 minutes to one hour. I will ask them about the things they can remember about coming to the Clinic. The interviews will be recorded on a tape.

**** ***** or **** ***** will be around to talk more if the young person needs to.
The interview will take place at the clinic.

The young person does not need to prepare in any special way for the interview. I am interested in hearing their views.

Are there any risks?

Some people may find talking about coming to the Clinic a bit upsetting. It is unlikely that they will feel like this, but if they do:

- I am a trainee clinical psychologist and they can talk with me
- They can talk with **** ***** or **** ***** afterwards.
- We can stop the interview at any point and no one will mind.

Some people might feel nervous about talking with me. If it would help, the young person can have a friend or family member come in to the interview with them to help them feel more comfortable.

Will they gain anything?

Some young people enjoy having an opportunity to express their views about services they have attended. They feel respected and listened to. The information we get from the study may help us improve therapy for future individuals and help the team think about young people’s views. There will, however, be no direct gains for the young person.

What if something goes wrong?

It is unlikely that anything would go wrong. However, if you do feel that something has happened that you do not like, you can contact the person you met with and they will help you to make a complaint. You can also contact the Patient Advice and Liaison Service (PALS) on **** *****. PALS is a confidential service to support clients, relatives and carers and acts independently when seeking resolutions.
Will what they say be kept private?

**** ***** and **** ***** will NOT be allowed to listen to the interview. I will type everything we say in the interview onto a computer and the tape will then be wiped. I will use a letter instead of the young person's name, and change or take out any information that would identify them. I will not say their name when I talk with supervisors who will help me with the research or when I write about the research. In the reports I might write out parts of what was said in the interview. No one will be able to know which young person said this.

All personal data (e.g. consent forms) will be stored at the Clinic. The researcher will store the written version of the interview for 5 years, as required by the University of Surrey.

What happens to what the researcher finds out?

I am doing this as part of my training to be a Psychologist. It will form part of the work I hand in for examination. A copy of the research will be kept in the library at the University of Surrey.

I also hope that the results will be published for other professionals to read. I will share what we find out with other professionals so they can learn from this too. All details that are personal to you will be changed or taken out of any report or talks that I give. I will also write a summary of the research for all young people who have taken part. You would be able to get a copy of this in the post or we could find a time to meet and talk about this. I will make copies of any published work available once these have been completed. These will be located in Clinic for you to access.

Has anyone checked the study?

The research has been checked by several people to make sure that it is alright. The West Sussex Local Research Ethics Committee, The University of Surrey Ethics Committee, and the Sussex NHS Research Approval and Monitoring Committee have all reviewed and approved this study.

What do I do now?

If you would like to take part in the study please complete the enclosed Participant Reply Slip and send it to me in the envelope provided. I will then contact you.
How can I find out more about this study?

If you would like to find out more about the research please ring me on *****

If you agree to take part in this study you will be given a copy of this information sheet and a signed consent form to keep.

Thank you for reading this information.

Jodie Tilley
Trainee Clinical Psychologist
Department of Psychology
University of Surrey
Guildford GU2 7XH
Appendix 8 – Consent Form - person with parental responsibility and young people 16 years and over
HEADED PAPER - NHS

Research Consent Form
(Person with parental responsibility and Young people 16 and over)

Research Title:

Young people’s experiences of attending Solution-focused brief therapy

Name of Researcher:

Jodie Tilley

Please initial box

1. I confirm that I have read and understand the information sheet dated ................. (version ................. ) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I consent to an audio-tape being made of the research interview and to all or parts of this recording being transcribed for the purposes of research and education. I understand that all information which could identify me will be anonymised. In understand that if I withdraw my consent the audi-taped information will be erased immediately.

4. I understand that the researcher will look at sections of my case notes to obtain information gathered during the therapeutic work. I give the researcher permission to access my records stored at the *** Child and Family Service.

5. I agree to take part in this study.

Name of Participant ____________________________ Date ________________ Signature _______________________

Name of Researcher ____________________________ Date ________________ Signature _______________________
Appendix 9 – Assent Form – young people aged between 11 and 15
Research Title:
Young people’s experiences of attending Solution-focused brief therapy

Name of Researcher:
Jodie Tilley

Please initial box

6. I confirm that I have read and understand the information sheet dated ............... (version .................) for the above study and have had the opportunity to ask questions.

7. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

8. I consent to an audio-tape being made of the research interview and to all or parts of this recording being transcribed for the purposes of research and education. I understand that all information which could identify me will be anonymised. I understand that if I withdraw my consent the audio-taped information will be erased immediately.

9. I understand that the researcher will look at sections of my case notes to obtain information gathered during the therapeutic work. I give the researcher permission to access my records stored at the **** Child and Family Service.

10. I agree to take part in this study

Name of Participant Date Signature

Name of Researcher Date Signature
Appendix 10 – Topic Guide
Topic Guides and Example Questions

**General questions (to build rapport and put participant at ease)**

Can you tell me a bit about yourself and the things that you like to do?

**Topic 1: Reason for attending**

Do you remember why you came to the Clinic?

Would you like to tell me about this?

**Topic 2: Coming to solution focused therapy**

Can you remember what it was like to come to your first session?

How might a boy or girl your age feel about coming to their first session with **** or ****?

What were your hopes for meeting with ****/****?

Who came to the sessions?
   How was this decided?
   Was this okay?

**Topic 3: What happened during the sessions?**

What used to happen at your appointments?

If another boy/girl the same age as you was coming to the Clinic for the first time what would you tell them to expect?

How might they feel after the first session?

When coming back for the next session, what should they expect?

How might they feel going into a second session, or ones after that?
**Topic 4: Change during therapy**

Did anything change or get better? Can you tell me about these changes?

If things didn’t change can you tell me why?

**Topic 5: Finishing solution focused therapy**

How was the decision to stop coming to the Clinic made? OR How do you think you will know when you are ready to finish?

Looking back on your sessions what, if anything, has happened during these sessions that you feel was important/helpful?

Is there anything that Psychologist 1 or 2 could have done differently?

What sort of person would find this type of therapy helpful?

**Topic 6: Other**

Is there anything else that you would like to tell me about your visits to the Clinic?

Is there anything I haven’t asked you that’s important?

Can you tell me what it was like for you to do this interview?

**Additional prompts/probes:**

This is a semi-structured interview and therefore the questions may be asked in a different order or might be changed slightly depending upon the interviewees’ responses. The interviewer will follow up these questions with prompts, which will vary depending upon the individual’s response.

**Example prompts:**

- *Could you tell me more about that?*
- *What makes you say that?*
- *What happened then/after that?*
- *How did that feel?*
- *What was that like?*
Appendix 11 – Sample of transcript
Sample of Transcript

I = Interviewer
P = Participant

I: Okay so, when you started, when you first started speaking to your doctor and things, you said you kept on going back to see him and then he referred you here to the clinic

P: yeah,

I: Um and you thought you might have a 9 month wait but um you got through in about 4 months um that felt really good because you were quite looking forward to being able to talk to somebody who wasn’t a friend or your family.

P: yeah

I: okay, and had you, did you meet with anybody else apart from Psychologist 2, here in the service or was she the first person?

P: she was the first person yeah

I: and had you met with any other different professionals in the past before?

P: No not at all

I: Right okay, so if you remember back to that very first um time when you were coming along her to meet Psychologist 2, so nearly a year ago now, um what was going through your mind before you came along for that first appointment?

P: Well um, I was really scared because I didn’t know really what sort of questions would be asked what I’d be allowed to tell and what really would be said, so I was just kind of like really, partly I didn’t want to come because I was worried about what would happen, but um when I got here, it was really good, just being able to talk

I: What was it about when you got here that meant it was really good,

P: I think really just being able to express my feelings um, to somebody that I didn’t really know and knowing then that it would stick to them and it wouldn’t really go on to anybody else,

I: oh okay so it was just kept between you and Psychologist 2, that was important was it?

P: yeah, yeah

I: They weren’t going to share that information or tell other people what you told them,

P: No
I: and you said that when you were, before you came you were thinking, um you weren't too sure what you were going to be able to and allowed to tell and things, can you tell me a bit more about that? What your worries were,

P: Umm, I was just worried that I wouldn't be able to talk over my problems um and sort of I wouldn't be able to say what I thought was sort of bringing on the [names problem] and I was worried that I wouldn't be able to discuss what it was that was causing them, that I thought, but when I got here it was quite good.

I: You were able to

P: yeah,

I: So were you worried that they wouldn't want you to talk about that, or that it would be difficult to say those things?

P: I was worried that they wouldn't really want to know, and that they would sort of just say um well we just want to concentrate on getting you better, which I know I've got to do that, but I think it helps me to talk about why I think I do them

I: and were you able to do that when you came along to the appointments?

P: yeah, the first couple of times I was able to yeah,

I: What was that like?

P: It was quite hard, but um yeah I think yeah I think it was good

I: And how did you know that they were happy for you talk about those things?

P: Umm they sort of listened and just commented back to things that I said um and just sort of said their opinion about like, not horribly but sort of just said, well lets try and focus on the good things about it instead of all of the bad, but they let me talk about it which was really good.

I: What do you think it would have been like if you weren't able to talk about the things that were difficult as well?

P: Then I think I'd still be where I was, I don't think I would have progressed at all

I: Right so that was helpful to be able to say what you thought had led to some of your obsessions and worries and what to be able to talk about those things first before thinking about the 'what do we need to do to get better' sort of thing, it was good to have that to start with.
P: yeah,

I: Okay, that's good, so when you came to that first appointment you said you felt quite scared, but once you got in here you felt better

P: yeah,

I: at what point did you notice yourself feeling a bit better?

P: Well I suppose it wasn’t until maybe a week or so later, and things started to improve at home and I felt better in myself and um then when I sort of thought back about when I came here it just sort of made me feel happy and um, but over time it’s just sort of got better and better, and so it wasn’t like an immediate thing,

I: right so it was a gradual process, okay, and can you describe for me what happened in the first sessions you had with Psychologist 2, what actually happened, what you talk about, what was the things that happened?

P: Um, well we just sort of talked, well I sort of got asked why I sort of done what I did like with the [names problems] and um I found that quite hard to answer but um it was sort of loads of um why do you think you do it, and why do you need to do it, and because I thought something bad was going to happen and um I just found that like it made a lot of sense what they were saying and that, [...] so it was just sort of common sense, but I was so low I couldn’t see that it was going to help if I did not do them, if that sounds right, yeah

I: okay so having the chance to talk it through was helpful because it enabled you to think about it in a different way to how you were thinking about it at home on your own?

P: yeah, yeah it was good.

I: And so they asked you lots of questions about 'why' you thought you were doing the things, and you said that was quite hard to answer, why was that hard, can you tell me a bit more about that?

P: Umm, I think it was because I’d never sort of asked the questions before and I’d never had to answer them

I: okay, so it was new things that you were thinking through,

P: yeah, and then when I thought about it, it made me feel quite upset, because I didn’t understand why it was happening to me and umm I just thought my life was falling apart and I didn’t know what I’d done to sort of make things turn out like what they were, but umm things have changed now
Appendix 12 – Example of coded transcript
J. Tilley

Major Research Project

17

the praising, all the praising from people even when I don't know them and like
they're just helping me and that, they're praising me and then they're giving ya targets
your, it's not really a target, it's your just you know you're going to do it,

I: right you know your going to do it

P: or you know you're going to try and do it your hardest and like try and make it work

I: it sounds like she was praising you for trying hard as well, which helps you to get
towards the targets

P: yeah of course, praising me for everything I done good

I: right,

P: and when I done bad, she didn't not praise me. she didn't say I was a bad person, she
just said let's try it a different way, and then I'd have like a different type of target,
similar, it's all based on the same thing but it's a different way of doing it and then, then
that's good because it shows me more than one way of trying to sort things out between
ourselves

I: right so you tried out some different ways to do things

P: yes we did

I: okay, so what else happened during the sessions, like from the, if you could tell me
what happened from the beginning you obviously had these questions and stuff was there
anything else that happened each week or each time you went that was important?

P: [long pause] not really

I: okay, so that's mainly the questions they asked you then is it?

P: yeah and like when I said about myself, like cause it's not just questions they ask me,
it's when I'm telling them how it's going for me, how I'm feeling, what I'm doing, how
much effort I'm trying to put in and I am putting in and that. And that is well me telling
them and understanding, and understanding them, and them understanding me and that as
well, it's just me telling them how I'm feeling and it's not all the questions because I'm
actually asking umm "I feel that didn't work", "I feel umm I feel that that was, I
tried it, but that was too hard" and then they'd say that, and then I could basically if I
wanted I could say I ask them questions, and that's good, but I've never asked them any
questions but it was good to know, because I could say like umm "how do you feel it was
helping", like "how do you feel it's going" and that, like "is it do you feel this is going
someplace", "is it actually doing something", "do you feel good in this, like talking to me

I: [long pause] not really

P: [long pause] not really

I: okay, so that's mainly the questions they asked you then is it?

P: yeah and like when I said about myself, like cause it's not just questions they ask me,
and that. I could ask them questions like that, but I let that lay, because I felt I knew how they were feeling.

I: oh okay, so you felt you didn’t actually need to ask them because you knew

P: yeah I felt I knew

I: So is it, am I right in understanding that it’s important that you were able to tell them whatever you wanted it wasn’t just about them asking you certain questions

P; yeah

I: you could tell them whatever was important to you and they would listen and try and understand

P: yeah

I what you were telling them about

P; yeah, that’s good, that’s good

I: So when you think back over the times that you’ve met with Psychologist 2 have any changes happened during this time? Has anything changed?

P: yeah, ummm my attitude and like I still have my bad moments obviously because like everyone does I still get hyped up too hyper sometimes but umm I’m my sisters are not much of an issues no more, I mean we still have our problems our disses and that but I’m much better with them, much better with them than I was ummm. At school I haven’t been at trouble at school in god knows how long now since I’ve been meeting with her there’s not been problems at school like I haven’t been told off, see I can’t even remember the last time I got told off and that’s changed and also I’ve been able to talk to people more ummm actually like and I’ve been able to um feel like, I should anyway, but I didn’t really feel it, I feel good in myself which and I’ve got more trust

I: Oh have, and how do you think these changes have happened?

P: Well I can’t really, basically it’s because I’ve worked so hard and that with it, but I suppose if it weren’t for my mum saying how she felt, my auntie saying how she felt and the things the lady (Psychologist 2) saying umm, praising me and saying this might help and try it out and all that, umm and myself doing them things and that, I doubt if that weren’t there I would never have thought of these I would never have thought what I thought of and I just, it wouldn’t be this way I’d still be a little rebel, but when you’ve got that it does, it does in a way changes you and then you feel like, you are, like I said you are somebody you can do it and like just don’t give up and that changes you as well cause then you’re nicer all round and you don’t really think of getting in trouble. You
Appendix 13 – Preliminary clusters of themes for first participant
Preliminary Clusters of Themes for Participant 1

IMPACT OF THERAPY
- Change in behaviour/symptoms
- Change at interpersonal level - relationships with others
- Change in wider system
- Development of new beliefs/views of self and world
- Increased self-esteem, confidence and self worth

PROCESS OF CHANGE
- Combination of factors lead to change
- Therapist encourages de-construction of change
- Pace of change is gradual
- Ownership of change process
- Self-evaluation of change/progress

CONTROL
- Control over the content of sessions
- Control over the pace of sessions
- Feeling out of control prior to commencing
- Importance of knowing what happens in therapy process
- Child active part of the process

PRE-THERAPY
- Beliefs about therapy prior to commencing
- Pre-therapy hopes
- Pre-therapy conflicting emotions
- Realisation I needed help

HELPFUL ASPECTS OF THERAPY
Scaling
- leads to understanding
- motivating
- measuring progress
Trial and error approach
Target/goal focused
Non-confrontational approach
Praise
- achievements
- effort
- impact of praise on self-esteem
- praise is motivating
Realistic approach

Feeling heard and understood
Problems normalised

EXPERTISE
therapist
client

IMPORTANCE OF SIGNIFICANT OTHERS
work as a team (client, family and therapist)
provide support
increases motivation
from outside of family
to provide alternative perspectives

WHAT HAPPENS IN THERAPY

Finding solutions to problems
Concentrating on what works
Co-constructing solutions
Identifying resources/assets
Therapist facilitates creativity in finding solutions
Absence of negative feedback

Problem free talk
facilitates development of therapeutic relationship
externalising problem

Talking about the problems
identification of problem at outset of therapy
focused on what's hard
Cathartic

THERAPEUTIC RELATIONSHIP FACTORS
Trust
Honesty
Perceived reciprocity
Connectedness
Therapists personality
Respect
Therapist believes in me
Therapist likes me
Therapist giving advice
Feeling respected and valued by therapist
Facilitative conditions created by therapist
genuine
non-judgemental
interested in me
feeling comfortable
Confidence in therapeutic approach
Identification with therapist

CLIENT FACTORS
Importance of Self-talk
Motivation as a pre-requisite for change
Motivation facilitated by therapy process
Self-reflection
Therapy can be challenging

INSTILLATION OF HOPE
Self-belief
Belief from significant others
Belief from the therapist
Hope

IMPORTANCE OF ENDING
- saying goodbye
- taking ideas forward

REFLECTING ON THERAPY
Appreciating/Valuing therapy
Therapeutic Setting
- Mirror and team – feeling listened to
- Environment used to facilitate change
Small things are important
Focus on having enough time to succeed
Time in between sessions is important
Appendix 14 – Preliminary clusters of themes for second participant
Preliminary Clusters of Themes for Participant 2

CONTROL

Client led - Control over the pace of therapy
  frequency of sessions
  time within sessions - allows young person to have personal space to think
  comforting
  reinforces the idea that change takes time
  responsibility
  setting goals
Therapist led
  Control over the content of sessions
  Therapist as expert
Desire to have more control over content of sessions
Therapist facilitated the setting of goals/aims
Client active participant in sessions
  reflecting on therapy and therapist actions
  reflecting on progress

THERAPEUTIC RELATIONSHIP FACTORS

  therapist acts like a friend
  trust
  confidentiality
  therapist factors

  Therapist’s non-judgemental approach
  Separateness of therapist
  Therapist was responsive to needs
  Therapist gave advice
  Therapist’s advice ‘fits’

VIEWS PRETHERAPY

Realisation I needed help
Perception/understanding prior to therapy
  problem defines me
  self-blame
  feeling out of control
Symptoms identified as reason for attending therapy
Conflicting emotions about coming to therapy
  Wanting to come and get help
  worried about what would happen
Client hopes
  to feel better about self
  to understand problems and origins

WHAT HAPPENS IN THERAPY?

Importance of talking
  reassures
  helps you open up
  helps
  can be hard
  is emotional
  cathartic
  feel exposed

Exploring problems
  opportunity to explore problems at beginning of therapy process
  lack of opportunity to explore problems later in therapy process
Importance of de-constructing problems
  Expectation that problems will be discussed
  Perception of exploring the reasons behind symptoms
  Fear that talking about problems could make them worse
  Therapists questions facilitated exploration of self and problem

Active listening

CHANGE

Process of change
  small steps can be maintained
  gradually build on progress
  step-by-step approach
  Trial and error approach to finding solutions

Pace of change
  Immediacy of change
  Change is gradual – realistic

Types of change
  change in affect
  change in behaviour
  change in problem
  change in cognitions
  change in relationships
  change in whole life
Changing view of self – emerging new positive views
  Therapy increases self-esteem
  Reappraisal of beliefs following changes in behaviour
Ownership of change
Changes can be initially vulnerable

CLIENT FACTORS

Client’s awareness of what solutions work
  behavioural
  cognitive

Client Motivation
  to change
  to attend therapy
  to talk about difficulties
  to be active in and between sessions

Model of understanding
  of how mood affects behaviour
  how feared consequences maintained behaviour
  Focus on the positives to facilitate change

Normalising Problems
  setting
  therapist reassurance

Valuing therapy – positive experience

Therapy environment – mirror made me feel nervous

Importance of using child-appropriate language

Impact of significant others
Appendix 15 – Table of emerging themes
### Table of Master themes, super-ordinate categories and sub-themes

<table>
<thead>
<tr>
<th>Master Theme</th>
<th>Super-ordinate Category</th>
<th>Sub-theme</th>
</tr>
</thead>
</table>
| 1. Entrance to Therapy | 1. Reason for seeking therapy | - identified problems  
- to gain insight and understanding  
- how initiated  
- previous attempts to change |
| | 2. Views pre-therapy | - Anticipatory anxiety  
- Expectancy/hope for change  
- dis-confirmation of negative expectations |
| 2. Therapist Relationship factors | 1. Therapist’s role | - Provide ideas/suggestions  
- to listen and support |
| | 2. Therapist’s personality and attitude | - facilitative personality factors  
- non-judgemental attitude |
| | 3. Therapists position | - Separate outsider  
- Experienced |
| 3. Elements of SFBT that supported the change process | 1. Getting to know me (problem free talk) | - reduces anxiety  
- facilitates development of therapeutic relationship |
| | 2. Therapy Conversations | - Importance of talking about problems  
- Focus on improvements, positives, and solutions |
| | 3. Usefulness of Scaling | - measuring progress  
- motivating |
| | 4. Importance of Praise | - effort and achievements  
- Increases self-esteem  
- motivating |
| 4. Facilitative factors in the process of change | 1. Client motivation | - pre-requisite from client  
- experienced within therapeutic arena |
| | 2. Approach to change | - Realistic aims  
- Trial and error approach  
- goal focused |
| | 3. Importance of significant others | - to provide support  
- to hear alternative perspectives |
| | 4. Fortuitous events | - mobilise change |
| 5. Reflections on Therapy | 1. Range of improvements | - Change occurs gradually  
- behaviour/affect/cognitions  
- relationships  
- self-esteem  
/confidence/emerging new views  
| 2. Reflections on the therapeutic experience | - Views of therapy experience  
- Combination of factors lead to change  
- Suggestions for improvements  
| 6. Control | 1. Control over therapy | - Therapist directing therapy  
- Collaboration between client and therapist  
- Client directing therapy  
| 2. Control over change | - Viewing therapist as responsible for change  
- Therapist encouraging ownership of change  
- Developing internal locus of control  |
Appendix 16 – Participant table of quotes
<table>
<thead>
<tr>
<th>Super-ordinate Category</th>
<th>Participant 1</th>
<th>Participant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for seeking therapy - identified</td>
<td>&quot;I was very stressy&quot; (6:30)</td>
<td>&quot;I ... used to ... cry all day ... feeling really depressed and low&quot; (5:2)</td>
</tr>
<tr>
<td>problems</td>
<td></td>
<td>&quot;I didn't understand why...&quot; (9:17)</td>
</tr>
<tr>
<td>- to gain insight and understanding</td>
<td>&quot;I asked for it myself and that's good for me&quot; (6:37)</td>
<td>&quot;I went to my doctors ...&quot; (5:15)</td>
</tr>
<tr>
<td>- how initiated</td>
<td></td>
<td>&quot;well I tried so long ...&quot; (10:6)</td>
</tr>
<tr>
<td>- previous attempts to change</td>
<td></td>
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</tr>
<tr>
<td>Views pre-therapy</td>
<td>&quot;a little bit nervous&quot; (7:35)</td>
<td>&quot;I was worried&quot; (6:31)</td>
</tr>
<tr>
<td>- Anticipatory anxiety</td>
<td></td>
<td></td>
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<tr>
<td>- Expectancy/hope for change</td>
<td>&quot;I was happy because I wanted help&quot; (10:43)</td>
<td>&quot;I was so happy to be able to talk to somebody&quot; (5:23)</td>
</tr>
<tr>
<td>- dis-confirmation of negative expectations</td>
<td>&quot;they're lovely people&quot; (13:23)</td>
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<tr>
<td>Therapists role</td>
<td></td>
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<tr>
<td>- To provide ideas/suggestions</td>
<td>&quot;saying this might help&quot; (18:39)</td>
<td>&quot;They sort of gave me ideas ...&quot; (9:31)</td>
</tr>
<tr>
<td>- to listen and support</td>
<td>&quot;The most helpfulest thing she does is listen&quot; (21:24)</td>
<td>&quot;listened and just commented back to things that I said&quot; (7:43)</td>
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<tr>
<td>Therapist's personality and attitude</td>
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<tr>
<td>- facilitative personality factors</td>
<td>&quot;she's interested&quot; (6:10)</td>
<td>&quot;a friend ... that I could trust her and really sort of open up&quot; (14:23)</td>
</tr>
<tr>
<td>- non-judgemental attitude</td>
<td>&quot;she wouldn't judge me for being a bad person&quot; (15:36)</td>
<td>&quot;doesn't seem to let the bad change her opinion of me&quot; (11:16)</td>
</tr>
<tr>
<td>Therapists position</td>
<td>Getting to know me</td>
<td>Therapy conversations</td>
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<td>---------------------</td>
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<tr>
<td>- Separate outsider</td>
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<tr>
<td>- Experienced</td>
<td>“to talk to someone who knows, understands kids like that [me]...” (21:24)</td>
<td>“it's showing interest in you ... I'll tell them things I wouldn't normally tell people” (15:24)</td>
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<td>- reduces anxiety</td>
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<tr>
<td>- facilitates developement of therapeutic relationship</td>
<td>“it's showing interest in you ... I'll tell them things I wouldn't normally tell people” (15:24)</td>
<td>“somebody else knew how I felt ... reassured ... normal” (15:18)</td>
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<tr>
<td>Therapy conversations</td>
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<tr>
<td>- Importance of talking about problems</td>
<td>“get it off my chest if there's a problem ... hear me out to understand me” (11:44)</td>
<td>“somebody else knew how I felt ... reassured ... normal” (15:18)</td>
</tr>
<tr>
<td>- Focus on improvements, positives, and solutions</td>
<td>“she’ll ask my mum like has she seen goodness in me like, changes in me and that” (8:6)</td>
<td>“concentrating on who I am ... but improving things” (14:35)</td>
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<tr>
<td>Usefulness of Scaling</td>
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<tr>
<td>- measuring progress</td>
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<tr>
<td>- motivating</td>
<td>“I'm gonna get an 8 and then you work even harder” (21:44)</td>
<td>“concentrating on who I am ... but improving things” (14:35)</td>
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<tr>
<td>Importance of Praise</td>
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<td>- effort and achievements</td>
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<tr>
<td>- Increases self-esteem</td>
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<tr>
<td>- motivating</td>
<td>“saying how well I've done” (7:12)</td>
<td>“somebody else knew how I felt ... reassured ... normal” (15:18)</td>
</tr>
<tr>
<td>- motivating</td>
<td>“makes me feel like I’m ... special” (7:26)</td>
<td>“somebody else knew how I felt ... reassured ... normal” (15:18)</td>
</tr>
<tr>
<td>- motivating</td>
<td>“gives you a boost” (7:10)</td>
<td>“somebody else knew how I felt ... reassured ... normal” (15:18)</td>
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<tr>
<td>Client motivation</td>
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<td>- pre-requisite from client</td>
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<tr>
<td>- experienced within therapeutic arena</td>
<td>“she [therapist] made me feel it is going to work” (16:4); “because she believed in me” (21:16)</td>
<td>-</td>
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<tr>
<td><strong>Process</strong></td>
<td><strong>Importance of significant others</strong></td>
<td><strong>Fortuitous external events</strong></td>
</tr>
<tr>
<td>- Realistic aims</td>
<td>- to provide support</td>
<td>- mobilise change</td>
</tr>
<tr>
<td>- Trial and error approach</td>
<td>- to hear alternative perspectives</td>
<td>-</td>
</tr>
<tr>
<td>- goal focused</td>
<td>“you need some people to be there, to do it with you to help you do it” (19:34)</td>
<td>“my friend’s mum died … really sort of put things into perspective” (23:14)</td>
</tr>
<tr>
<td></td>
<td>“I like to hear my mums point of views …then you get an idea of how people feel” (Part 2 8:6);</td>
<td>-</td>
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<tr>
<td></td>
<td>“I’m very realistic like it’s not realistic to be always good” (6:2)</td>
<td>“with my mum, we sort of sit down and really concentrate…” (19:34)</td>
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<td></td>
<td>“lets try it a different way” (17:17)</td>
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<td></td>
<td>“targets to aim for to see if they’d work” (5:20)</td>
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<tr>
<td><strong>Range of improvements</strong></td>
<td>- Change occurs gradually</td>
<td>- but over time …got better and better” (8:27)</td>
</tr>
<tr>
<td>- behaviour/affect/cognitions</td>
<td>“my attitude … but I’m much better with them [sisters] … I haven’t been at trouble at school”(18:25)</td>
<td>“made a lot more friends … I’m happier and not always so depressed and down” (21:13)</td>
</tr>
<tr>
<td>- relationships</td>
<td>“I’ve been able to talk to people more”</td>
<td>“me and my mum … get on a lot better” (22:22)</td>
</tr>
<tr>
<td>- self-esteem/confidence/emerging new views</td>
<td>“I feel good in myself” (18:33)</td>
<td>“I’m a lot happier in myself …” (21:12)</td>
</tr>
<tr>
<td>Reflections on the therapeutic experience</td>
<td>“helped me a lot” (21:5)</td>
<td>“having to open up has really, really helped” (23:34)</td>
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<td>------------------------------------------</td>
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</tr>
<tr>
<td>- Views of therapy experience</td>
<td>“altogether it’s just all helped” (19:24)</td>
<td>“it all sort of all helps” (22:9)</td>
</tr>
<tr>
<td>- Combination of factors lead to change</td>
<td>“I think she did a perfect job” (24:3)</td>
<td>“they could change the format ...to sort of ask what we want to cover” (25:18)</td>
</tr>
<tr>
<td>- Suggestions for improvements</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Control over therapy</th>
<th>&quot;She just give us like me targets just to work towards&quot; (5:27)</th>
<th>“I got told that um they didn’t need to know about that” (18:26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Therapist directing therapy</td>
<td>“a bit like a board game like you take turns” (21:30)</td>
<td>“helped me to focus on ...” (21:24)</td>
</tr>
<tr>
<td>- Collaboration between client and therapist</td>
<td>“I get to say... I can say like how many months ... I feel I need to try and reach my target” (11:12)</td>
<td>“[Psychologist] actually asks me when I think it would be suitable for me to come back which I really like the idea of” (20:19)</td>
</tr>
<tr>
<td>- Client directing therapy</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Control over change</th>
<th>“how did you do that like how did you solve that yourself” (15:5)</th>
<th>“lets me think about how long I’ll need until I’m ready” (20:25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Viewing therapist as responsible for change</td>
<td>“I’m the one whose done it” (19:25)</td>
<td>“…change their lives which is what [Psychologist] has helped me to do” (25:33)</td>
</tr>
<tr>
<td>- Therapist encouraging ownership of change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Developing internal locus of control</td>
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</tbody>
</table>


<table>
<thead>
<tr>
<th>Super-ordinate Category</th>
<th>Participant 3</th>
<th>Participant 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for seeking therapy</td>
<td>“I'm trying to get through my …” (8:7)</td>
<td>“to get over this [problem]” (4:40)</td>
</tr>
<tr>
<td>- identified problem to overcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- to gain insight/understanding</td>
<td>“they asked me whether I wanted to go and see her, and not mum” (7:37)</td>
<td>“she [mum] went to see our local doctor … he suggested umm coming here” (4:14)</td>
</tr>
<tr>
<td>- how initiated</td>
<td>“I felt I didn’t get very much help [in previous therapy]” (8:8)</td>
<td>“my mum had tried everything, since I was like 6 years old, like tried …” (4:11);</td>
</tr>
<tr>
<td>- previous attempts to change</td>
<td></td>
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</tr>
<tr>
<td>Views pre-therapy</td>
<td>“I felt fine”(4:26)</td>
<td>“confused and a bit nervous” (12:39)</td>
</tr>
<tr>
<td>- Anticipatory anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Expectancy/hope for change</td>
<td>“that she'd probably be able to help” (11:40)</td>
<td>“it would be nice and I'd feel more free” (4:40)</td>
</tr>
<tr>
<td>- dis-confirmation of negative expectations</td>
<td>“I thought she'd just talk and try and get it over and done with” (8:35)</td>
<td>“it's not like a blood sample … loads of mental tests … it's just a chat really” (9:6)</td>
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<tr>
<td>Therapists role</td>
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<tr>
<td>- To provide ideas/suggestions</td>
<td>“their job to talk to you” (5:19)</td>
<td>“she suggested … (15:17)</td>
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<tr>
<td>Therapist's personality and attitude</td>
<td>&quot;really nice… acted like a friend&quot; (9:1)</td>
<td>“they were nice people, yeah it helps if someone's nice”</td>
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<tr>
<td>- facilitative personality factors</td>
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<tr>
<td>- non-judgemental attitude</td>
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<tr>
<td>Therapists position</td>
<td>“talking to someone else who you don't know” (11:18)</td>
<td>“she seems to have a lot of experience with helping people overcome things” (24:30)</td>
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<tr>
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<table>
<thead>
<tr>
<th>Quote</th>
<th>Time</th>
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<tbody>
<tr>
<td>“she would know a lot about me...she would understand it”</td>
<td>10:44</td>
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<tr>
<td>“to settle you in a bit”</td>
<td>15:9</td>
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<tr>
<td>“it was just nice to get to know them, before they started asking me like what the problem...”</td>
<td>5:29</td>
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<tr>
<td>“what my [problems] were”</td>
<td>11:29</td>
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<tr>
<td>“They just asked me about the problems I had with...”</td>
<td>5:39</td>
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<tr>
<td>“easiest ... which I thought ... to defeat them”</td>
<td>14:26</td>
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<td>“did it work for you, um if it didn't have you got any other suggestions for things that might work”</td>
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<tr>
<td>“see how you’ve progressed”</td>
<td>9:25</td>
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<td>“I think it's like a progression chart for you”</td>
<td>18:29</td>
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<td>“I thought it was helpful, to like see myself on a scale... it was like hmmm I wanna do more than that”</td>
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<td>“so I could work it”</td>
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<td>“I think they were a bit proud of me because I’d tried something and carried on ... that was a big step so”</td>
<td>16:22</td>
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<td>“I think I definitely needed motivation ... a couple of years ago I didn’t have any ...but now I do want to change”</td>
<td>8:43</td>
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<td>“you get the motivation from the professionals ... see here”</td>
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<td>Process</td>
<td>“how long it would take me to like get up a couple of levels” (12:4)</td>
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<td>- Realistic aims</td>
<td>“where I wanted to get” (14:26)</td>
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<td>- to hear alternative perspectives</td>
<td>“get the full thing out of her [mum] … mostly get our side” (6:17)</td>
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<td>Fortuitous external events</td>
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<tr>
<td>- mobilise change</td>
<td>“because I had to go up one floor for something, and I had to stay the night at my friends” (17:31)</td>
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<tr>
<td>Range of improvements</td>
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<td>“more likely to go round other people's houses” (17:17)</td>
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<td>- Views of therapy experience</td>
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</table>
| - Combination of factors lead to change  
| - Suggestions for improvements | “it was helpful all round kind of but not majorly” (18:12) | “shorter session like 40 or 45” (24:12) |
|                                | “because all they could do was talk …I needed a more practical approach” (16:20) | |

**Control over therapy**
- Therapist directing therapy
- Collaboration between client and therapist
- Client directing therapy

|                                | - | - |
|                                | - | - |
|                                | - | - |
|                                | - | - |
|                                | - | - |
|                                | “they let me be in control of what’s happening” (24:6) | |

**Control over change**
- Viewing therapist as responsible for change
- Therapist encouraging ownership of change
- Developing internal locus of control

<p>|                                | - | “then they [therapist] won't know what things to do” (24:38) |
|                                | “how many I've got through” (9:21) | “I think they wanted to make me feel in control so that I’d feel in control more about my [problem]” (Part 5; 13:27) |
|                                | “I'm going to have to go do that by myself” (16:22) | “mostly it’s me doing the, suggesting what I want to try” (19:39); |</p>
<table>
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<tr>
<th>Super-ordinate Category</th>
<th>Participant 5</th>
<th>Participant 6</th>
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<tr>
<td><strong>Reason for seeking therapy</strong></td>
<td>&quot;just to sort out problems that were that I was facing&quot; (5:4)</td>
<td>&quot;Well I was having trouble ... it was uhh anxiety I&quot; (2:1)</td>
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<td>- identified problem to overcome</td>
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<td>- to gain insight/understanding</td>
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<td>- how initiated</td>
<td>&quot;my doctor here, he um said to my mum&quot; (9:27)</td>
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<tr>
<td><strong>Views pre-therapy</strong></td>
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<tr>
<td>- Anticipatory anxiety</td>
<td>&quot;I wasn't worried&quot; (6:42)</td>
<td>&quot;I was a bit worried ... didn't know what was going to happen&quot; (6:30)</td>
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<tr>
<td>- Expectancy/hope for change</td>
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<td>&quot;hopefully I'd be able to get back to ...&quot; (8:8)</td>
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<tr>
<td>- dis-confirmation of negative expectations</td>
<td>&quot;they're not going to like interrogate you or anything&quot; (10:17)</td>
<td>&quot;but I was alright with after I'd got here ... she just spoke to me like anyone else would speak to me&quot; (6:36)</td>
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<td><strong>Therapists role</strong></td>
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<tr>
<td>- To provide ideas/suggestions</td>
<td>&quot;they [therapist] suggested things&quot; (5:6)</td>
<td>&quot;she said about trying ...&quot; (7:6)</td>
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<tr>
<td>- to listen and support</td>
<td>&quot;to listen&quot; (10:19)</td>
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<td><strong>Therapist's personality and attitude</strong></td>
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<tr>
<td>- facilitative personality factors</td>
<td>&quot;they're quite friendly ... make you feel like you can open up to them&quot; (15:22)</td>
<td>&quot;she's nice &quot; (17:28)</td>
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<tr>
<td>- non-judgemental attitude</td>
<td>&quot;see them as just someone that's got problems ... they're not doing it to be like horrible&quot; (21:17)</td>
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<td><strong>Therapists position</strong></td>
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<tr>
<td>- Separate outsider</td>
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<td>&quot;when you come here and speak to different people … it's just different&quot; (15:6)</td>
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<tr>
<td>- Experienced</td>
<td>-</td>
<td>&quot;someone … who knows what it is, and what I'm going through&quot; (9:40)</td>
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<th><strong>Therapy conversations</strong></th>
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<tr>
<td>- Importance of talking about problems</td>
<td>&quot;relieved … it was good that I could tell someone my worries&quot; (11:6)</td>
<td>&quot;I went there to speak about … what was wrong and everything&quot; (4:25)</td>
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<tr>
<td>- Focus on improvements, positives, and solutions</td>
<td>&quot;well they don’t say anything negative, it’s always positive things&quot; (15:22)</td>
<td>&quot;asking me how I’m getting on now, and what improvements I’ve seen (6:11)</td>
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<tr>
<th><strong>Usefulness of Scaling</strong></th>
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<tr>
<td>- measuring progress</td>
<td>&quot;how would you say it is now which like compares it …” (13:1)</td>
<td>&quot;how I’m getting on&quot;(5:9)</td>
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<tr>
<td>- effort and achievements</td>
<td>&quot;they praise me because when I say like lots of things&quot; (13:27)</td>
<td>&quot;say like yeah he's improved … he's trying really hard&quot; (12:26)</td>
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<tr>
<td>- Increases self-esteem</td>
<td>-</td>
<td>&quot;helps me feel good in myself” (15:18)</td>
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<th><strong>Client motivation</strong></th>
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<tr>
<td>- pre-requisite from client</td>
<td>&quot;I’m going to … for my own good and for everyone else’s good” (17:31)</td>
<td>&quot;because I've got to try hard too” (17:9)</td>
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<tr>
<td>Process</td>
<td>Importance of significant others</td>
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<td>- goal focused</td>
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<td>“my mum took the light a few times so then I ... I’ve got no distractions, and that’s helped a lot that has ... mum wasn’t supposed to but ... that worked so ...” (14:19)</td>
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<td>“having someone you know there, it helps me, and she helps explain some things to me” (8:34)</td>
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<td>“speaking to my whole family too” (19:33)</td>
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<tr>
<td>Reflections on the therapeutic experience</td>
<td>“on the whole it’s been really good” (21:34)</td>
<td>“she helps and that it’s worth going to” (16:14)</td>
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<tr>
<td>- Views of therapy experience</td>
<td>“just all the techniques and them being friendly and not putting pressure on me” (21:41)</td>
<td>“it’s not something that needs to be improved really” (18:7)</td>
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<tr>
<td>- Combination of factors lead to change</td>
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<td>- Suggestions for improvements</td>
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<td>Control over therapy</td>
<td>“and they [therapists] are going to say whether I need to see them anymore, or whether it’s improved enough yeah.” (19:36)</td>
<td>“she’ll ask me the question” (5:39)</td>
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<td>“see if it had increased or got better with the help she’d given.” (5:14)</td>
<td>“they’ve helped me really” (14:15)</td>
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<td>- Viewing therapist as responsible for change</td>
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<td>- Therapist encouraging ownership of change</td>
<td>“they [psychologists] ...just like back up my when I say something, and they try and add to that the things I’m saying” (20:15)</td>
<td>“she said how long do you reckon you’ll need” (10:15)</td>
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<tr>
<td>- Developing internal locus of control</td>
<td>“actually I was surprised that ...the ideas that sometimes, well mostly all the time are mine” (13:44)</td>
<td>“it’s just like I tried it again, and started it all again, and just did it really” (11:32);</td>
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<tr>
<td>Super-ordinate Category</td>
<td>Participant 7</td>
<td>Participant 8</td>
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<tr>
<td>Reason for seeking therapy - identified problems</td>
<td>&quot;my behaviour … stuff at school&quot; (7:8)</td>
<td>&quot;I was having umm, problems with&quot; (4:6)</td>
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<td>- to gain insight and understanding</td>
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<td>; &quot;just give me insight&quot; (8:4)</td>
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<td>&quot;I wasn't too worried&quot; (7: 12-16)</td>
<td>&quot;nerve wrecking because I didn’t know her, she didn’t know me …” (5:13)</td>
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<td>&quot;at that time I couldn’t see it sort of getting better&quot; (8:25)</td>
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<td>&quot;more open than I thought&quot;(6:19)</td>
<td>&quot;but it was alright once I met her you know, she put me at my ease and that so it was alright&quot; (5:1)</td>
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<td>&quot;she’d explain things” (13:6)</td>
<td>&quot;giving me advice on how to go forward” (22:23)</td>
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<td>&quot;just be there as a sort of support&quot; (8:3)</td>
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<td>“I felt brighter in myself ... wanted to get out of bed in the morning” (17:41)</td>
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<td>“things that I could do all of a sudden that I couldn’t have seen myself doing before” (16:1)</td>
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<td>emerging new views</td>
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<tr>
<td>Reflections on the therapeutic experience</td>
<td>“yeah it [first session] helped a lot” (5: 16)</td>
<td>“it’s really gone up” (23:36)</td>
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<td><strong>J Tilley Major Research Project</strong></td>
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<tr>
<td>- Combination of factors lead to change</td>
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<td>&quot;advice ... just again having that person whose always there is nice&quot; (22:23)</td>
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<td><strong>Control over therapy</strong></td>
<td>&quot;She used to like set targets&quot; (7:41)</td>
<td>&quot;she'll discuss what she wants to get out of that current session&quot; (11:14)</td>
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<tr>
<td>- Therapist directing therapy</td>
<td>&quot;we set targets for whatever it was like&quot; (7:25)</td>
<td>&quot;she was just trying to walk me towards a solution really&quot; (9:37)</td>
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<tr>
<td><strong>Control over change</strong></td>
<td>&quot;she helped me&quot; (14:9)</td>
<td>&quot;I was very much hoping that she would be able to do something to help me, but no I couldn't really see how she was going to do that or about how that would come about&quot; (8:25)</td>
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<td>- Viewing therapist as responsible for change</td>
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<td>&quot;what you've been up to and doing to help it&quot; (11:10)</td>
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<tr>
<td>- Therapist encouraging ownership of change</td>
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<td>&quot;I have to try and make that happen&quot; (12:18)</td>
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<td>- Developing internal locus of control</td>
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Appendix 17 – Summary of Findings for the Participants
Covering Letter

Participants Address

August 2006

Dear,

Earlier this year, you participated in some research that I was conducting as part of my training to become a psychologist. I was interested in hearing about young people’s experiences of attending the clinic, and you agreed to talk with me about what this was like. Thank you again for the taking the time to meet with me and talk about your experiences, this has helped me to find out about what it is like to come to the clinic and attend therapy from your perspective.

I have now completed the interviews, examined the data and I have written the findings up for part of my training. Overall, eight young people took part in the research. Once I had completed the interviews I typed everything we said in the interview onto a computer and then analysed the data by looking for similarities and differences among all of the young people’s interviews. Some interesting findings came out about what it is like to come to the clinic and the important and helpful aspects of therapy. As you requested feedback on the findings, I have written a summary of the findings from the research which is included with this letter. The findings cover the shared experience of the all the participants rather than just your own personal experience.

If you have any questions or would like to make any comments on the results, you can contact me at ***** on ***** ********.

Thank you again for participating in the research which will help us to improve therapy for future individuals and help the team think about young people’s views.

Yours sincerely,

Jodie Tilley
Lead Researcher, Trainee Clinical Psychologist
Young people's experiences of attending the Solution-focused Therapy Clinic - Summary of the Findings for Participants

A number of themes came out of the analysis of the interviews which are summarised below. There were also some ideas about how to improve the experience of coming to the clinic which will be fed-back to staff at the Child and Family Service.

**Entering therapy**

All of the young people interviewed saw the clinic as a place where personal problems or difficulties could be overcome with the help of professionals. For some people it was important that it was their decision and choice to come to the clinic rather than being made to come by adults. Most people were nervous about coming to the clinic, feeling “worried”, “confused” and not sure about what was going to happen. Those who had come to meet with professionals before were not as worried, and everyone felt more relaxed after meeting the therapists.

**Therapist Factors**

The personality of the therapist was important to all of the young people. It was especially important that the therapist was friendly, polite, kind and understanding. Some people described how it was important that the therapist was a separate person from family and friends and this meant they did not take sides, did not become upset about what was said and had an “unblinkerred” view. The therapist also sometimes came up with ideas and made suggestions, and this was important and helped people find solutions to their difficulties. It was especially important that the therapist listened to what people were saying, understood them and did not judge them as being bad due to their difficulties. People felt understood and accepted by the therapist.

**Helpful aspects of Solution Focused Therapy**

1. “Getting to know you”

Most people thought that it was helpful and important that the therapist spent some time at the beginning “getting to know you”. This helped to make people feel relaxed and less nervous, showed them that the therapist was interested in them, and helped the therapist to be able to understand them better.

2. *Therapy conversations*

Everyone described how therapy was about talking. This involved being able to talk about difficulties or worries and some people thought this helped the therapist to be able to understand them and found it useful to be able to get worries off their chest. The sessions were mainly focused on talking about goals, looking for improvements, and coming up with ideas and solutions to try out. These conversations had a positive focus which made coming to the clinic less uncomfortable. Some individuals were keen to come back to sessions to talk about how much things had improved and how much they had achieved. One individual felt that it might be helpful to have more opportunity to talk about difficulties as well as think about solutions and improvements. Everyone described how the sessions were about talking about ideas and achievements and the time between sessions was important in giving the ideas a go.
3. **Usefulness of scaling**
Most people described how the therapist asked them to rate themselves on scales from 0 -10. This was thought to be a helpful way of measuring improvements and seeing how well they had progressed. For some people this also helped to encourage people to work harder and gave them a goal to focus on.

4. **Importance of praise**
Many people indicated that the therapist praised them and gave compliments (e.g. saying well done and good work). It was important that the therapist praised both hard work and any improvements, and this meant people could celebrate how well they were doing and feel proud. This made many people feel good about themselves, boosted their confidence and motivated them to keep going. It was helpful to be in a setting where the focus was on the good things that they were doing.

**Other factors that contributed to change**

1. **Self motivation**
Most people described how it was important that they were ready, keen and committed to make changes. This was especially important as therapy was sometimes “hard work” as new ideas and suggestions were tested out in the time between the sessions. For some individuals they knew that in the past they had not felt ready or keen to change and that this was necessary to successful therapy. For some people they found that attending therapy increased their motivation.

2. **Realistic, goal focused, trial and error approach**
It was important to set realistic goals and to not expect or hope for immediate changes overnight. It was also helpful for people if they were allowed to work at their own pace and be able to decide how long they needed to reach certain goals. It was important to set goals regularly and this helped people to picture what they were working towards. Many people described how it was a process of trial and error where different solutions were tried out to see if they worked.

3. **Importance of other people**
Most individuals indicated that they were able to choose whether any other family members attended the sessions with them, which was considered to be important. Family and friends were helpful in providing support both in the appointments and outside of the appointments. This included having parents in sessions to help to reduce nerves, hear different points of views, and support people to try out new ideas and make changes. Some people preferred to meet with the therapist on their own as this allowed them to open up more.

4. **External factors**
For some people, certain unexpected things happened outside of the sessions that were important in bringing about change. These were then sometimes talked about in the session. These events seemed to provide an opportunity for people to do things differently and encouraged them to make changes.

**Thoughts on therapy**
Most people came to therapy to overcome certain problems. In addition to overcoming these difficulties, most people noticed changes in many areas of their lives. This included changes in how they felt about themselves, acted towards others
and in their confidence. Many people described how they thought more positively about the future and were getting more out of life. The changes happened gradually over time, and most people thought that the sessions had helped them to bring about these changes.

Control

There was a mixture of young people feeling in control of the therapy and feeling that the therapists controlled this. Some people felt that the therapist set goals for them, where as others felt that they set their own goals or came up with them together. Some people found it helpful to be in control of some parts of the sessions. For example, many people liked being able to decide when to come back for appointments and being able to work at their own pace. At times it seemed that this helped them to feel in control of their difficulties and the changes that were happening. It was therefore important to be included in making decisions and in control of the sessions. Some people talked about how the improvement came about as a result of the help they received in the sessions. Many people described how the changes happened as a result of their own hard work and were proud of how they had bought about changes for themselves. This helped some people to feel positive about tackling new problems themselves in the future.

Conclusions and Recommendations

A number of findings and suggestions have come out of the research and will be fed-back to the service to help them think about young people’s experiences and ways to improve therapy for other young people in the future. Some of the suggestions included:

1. Thinking about the importance of praising young people, helping them to be in control of aspects of the sessions and the importance of self-motivation.
2. To focus on improvements, goals and successes whilst also allowing young people opportunity to talk about difficulties in their lives.
3. Giving young people more information about what might happen at the clinic and in the sessions before coming for the first appointment. This could be through a leaflet or flyer, which could be given out before the first appointment.
4. Thinking about how young people could help in the recruitment of staff for child and family services, as the personality and attitude of the therapist is very important to young people.
5. Asking young people about their experiences of therapy so that professionals can learn from them and so young people can have a chance to think about their progress and success.
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